WCA Group Health Trust
Crivitz School District

Medical Benefit Plan

Group Number: 76-440188
Revised: July 1, 2017

SUMMARY PLAN DESCRIPTION

EMPLOYEE MEDICAL PLAN FOR

WCA GROUP HEALTH TRUST
CRIVITZ SCHOOL DISTRICT

GROUP NUMBER: 76-440188

Underwritten By:
WCA Group Health Trust
22 East Mifflin Street Suite 900
Madison, Wisconsin
(866) 404-2700 (toll-free)

Effective Date: July 1, 2017

Authorized Representative	**Authorized Representative, WCA Group Health Trust**
Title	**Title**
Date	**Date**

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IMPORTANT MESSAGE

CHANGES IN ELIGIBILITY

You should report **ANY CHANGE IN ELIGIBILITY** to Your Employer as soon as possible. Changes in eligibility include:

- Marriage or divorce
- Death of any Dependent
- Birth or adoption of a child
- Dependent child reaching the limiting age
- Total disability
- Retirement
- Medicare eligibility

For specific details on maintaining coverage under the Plan, refer to SECTION 3 - ELIGIBILITY.

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SECTION 1 MEDICAL BENEFITS

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PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan, subject to the deductibles, copayments, maximums and all other terms, provisions, limitations, conditions and exclusions of the Plan.

PPO NETWORK INFORMATION

This Plan has PPO and Non-PPO benefits. A PPO provider is a Network provider. A Non-PPO provider is a Non-Network provider. Certain benefits in this Plan (e.g. the deductible, coinsurance and out-of-pocket limits) vary between the PPO and Non-PPO providers. PPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the Plan's incentives to use PPO providers. These contracts establish a fair market value for health care services, which in most cases will reduce Your costs.

Your Employer has contracted one or more PPOs to provide services to this Plan in the areas that it has Employees. Each PPO network consists of physicians, Hospitals and other medical care providers. The PPO that is applicable to You is shown on Your ID card.

WAIVER OF PREMIUM

For purposes of this provision, "You" refers to the Covered Employee.

If You are Totally Disabled for at least 60 consecutive days, the monthly premium (i.e. Plan contribution) will be waived for You and Your Covered Dependents. Such Waiver starts on the first day of the month following such 60-day period and ends on the earliest of the following dates:

1. The date You are no longer Totally Disabled;

2. The date You fail to provide proof of disability to the Employer;

3. The date You cease to be eligible for coverage under this Plan;

4. The date You become eligible for Medicare benefits;

5. The date You die; or

6. The date this Plan terminates for any reason.

This Waiver of Premium applies for a <u>maximum of 30 months</u> during any one Period of Disability, as described below.

Waiver of Premium will only apply:

1. If You become Totally Disabled after the effective date of this Plan;

2. If You are under the regular care of a Qualified Practitioner;

3. If You comply with the treatment plan prescribed by Your Qualified Practitioner; and

4. To the type of coverage that You had on the date that Your Total Disability started (i.e. single coverage or family coverage).

Waiver of Premium - continued

Waiver of Premium does not apply if You were Totally Disabled at the time of Your retirement and You are covered under the Retiree Coverage section of this Plan.

For complete information regarding the Waiver of Premium provision, please contact Your Employer.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

PRIOR AUTHORIZATION REQUIREMENTS

The Utilization Management company (UM) shown on Your ID card will handle the authorization requirements of Your Plan. You should call the UM for authorization as soon as possible to receive proper care coordination. However, You must call within the time frames shown below. The UM toll-free number is shown on the back of Your ID card.

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Inpatient Admission Authorization (Includes all inpatient admissions, such as, but not limited to: inpatient Hospital admissions, Extended Care Facility and inpatient Hospice.)	PPO: No penalty (for the Covered Person). Non-PPO: 25%, up to $250 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan. The penalty is not applied to the out-of-pocket limit	**PPO**: **Your PPO provider** is required to notify UM for authorization. **Non-PPO**: **You** must call UM for authorization at least five days in advance of any Non-Emergency inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 72 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require Prior Authorization. If You do not obtain authorization, benefits will be payable after the non-compliance penalty. If admission is on an Emergency basis, UM must be notified within 72 hours following Your admission, or as soon as medically possible	1-22
Chemotherapy	PPO and Non-PPO: No penalty.	**PPO and Non-PPO***:* You must call UM for authorization prior to starting any chemotherapy services. (For cancer diagnosis only.)	1-22
Kidney Disease	PPO and Non-PPO: No penalty.	**PPO and Non-PPO**: You must call UM for authorization prior to starting a course of renal dialysis.	1-22

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF COVERAGE.

MEDICAL BILL REVIEW

You should carefully review Your bill for any service. If You find any errors such as:

1. Treatment that is billed, but was not received;

2. Incorrect arithmetic;

3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bill, with the errors circled, and the corrected bill to the Claim Administrator. This serves as proof that the provider of service agreed to the corrections. **If You are correct, You will receive 50% of the errors in the bill, but not more than $500 paid per bill.**

SCHEDULE OF BENEFITS

NOTE: UMR, Inc. is the Plan's Claims Administrator. UMR, Inc. provides clerical and claims processing services to the Plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the Plan, nor is UMR, Inc. a fiduciary to this Plan.

MEDICAL BILL REVIEW

If You discover a billing error, report it to the Plan. As a reward, You will receive 50% of the error, but not more than **$500 paid per bill**. (Please refer to the prior page of this document for more information.)

MEDICAL BENEFITS

Plan Lifetime **Maximum:** Unlimited

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Plan Year PPO Individual Family Non-PPO Individual Family	 $0 $0 $0 $0	 $3,000 $6,000 $6,000 $12,000	The amount You must pay each year before the Plan will begin paying any benefits. The PPO deductible is separate from the Non-PPO deductible and vice versa. The family maximums are on an aggregate dollar basis. (No one Covered Person in the family may incur more than the Individual maximum amount per Plan Year.) Plan Year means July 1 to June 30.	1-21
Individual Coinsurance per Plan Year PPO Non-PPO	 100% 80%	 0% 20%	After the deductible, the coinsurance amounts shown apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-21

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Out-of-Pocket Limit per Plan Year PPO **Deductible and Coinsurance Limit** Individual Family **Combined Deductible, Coinsurance and Medical Copay Limit** Individual Family Non-PPO **Deductible and Coinsurance Limit** Individual Family **Non-PPO medical copay limit**		 $3,000 $6,000 $4,000 $8,000 $9,000 $18,000 Unlimited	Represents the total paid by You for the deductible, coinsurance, copays if applicable and embedded vision. After which the Plan pays 100% of Covered Expenses subject to any maximums. The PPO out-of-pocket limit is separate from the Non-PPO out-of-pocket limit and vice versa. The family maximums are on an aggregate dollar basis. (No one Covered Person in the family may incur more than the Individual maximum amount per Plan Year.) PPO: All copays are included in the out-of-pocket limit, **except** Prescription Drug copays. Non-PPO*:* Copays are not included in the out-of-pocket limit. Plan Year means July 1 to June 30.	1-21

The deductible and coinsurance limits shown above apply to all Covered Expenses unless stated otherwise below.

PPO Benefit Provision
Some benefits may be processed at the PPO benefit level when provided by a Non-PPO provider. The following exceptions may apply:

1. PPO benefits will be payable for Non-PPO provider services **only** if You receive treatment that is a Covered Expense from a PPO provider and as a result of that treatment, a Covered Expense is incurred for pathology, radiology, or anesthesiology services from a Non-PPO provider;

2. Covered Expenses provided by a Qualified Practitioner during an Inpatient stay will be payable at the PPO level of benefits when provided at a PPO Hospital;

3. Covered Expenses provided by an Emergency room Qualified Practitioner will be payable at the PPO level of benefits when provided at a PPO Hospital;

4. If there is not a PPO provider or no PPO provider is willing or able to provide the necessary services(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Non-PPO charges will be processed as PPO charges so long as the covered Person provides appropriate documentation.

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-23

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Qualified Practitioner Office Services Benefit	PPO: $25 copay per visit, then deductible/100% to coinsurance limit Non-PPO: $50 copay per visit, then deductible/ 80% to coinsurance limit **Convenient Care Clinic Benefit:** PPO: 100%, deductible and coinsurance waived Non-PPO: $50 copay per visit, then deductible/ 80% to coinsurance limit	This copay is taken on the office visit CPT procedure code. The balance of the office visit charge and other Covered Expenses are subject to the deductible and coinsurance. This copay applies to all office visits, unless the benefit specifically states that it does not apply. **X-rays and Lab Tests**: Payable as shown under the X-rays and Lab Tests benefit.	1-23
Qualified Practitioner Benefits	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Inpatient and outpatient Hospital visits, surgery and anesthesia. For doctors whose office is located in the Outpatient department of a Hospital, the office services benefit will be applied	1-23
Oral Surgery Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Refer to list of covered oral surgeries in text. **Extractions, Replacements and Dental Implants**: Limited to a combined maximum of $1,500 paid per Plan Year. (This dollar limit only applies to the CPT code for the extractions and the implants. The related services for the extractions and implants are not applied to the dollar limit.) The Office Visit copay does not apply to this benefit.	1-24

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	**Routine Physical Exams:** PPO: 100%, deductible and coinsurance waived Non-PPO: $50 copay per visit, then deductible/ 80% to coinsurance limit **Immunizations** 100%, deductible and coinsurance waived (for PPO and Non-PPO) **X-rays and Lab Tests** PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine immunizations and routine exams for school, sports and camps. Refer to the Wellness Benefit section of the Plan for details and limits. **For routine physical exams and well child exams only**: If any Covered Expense included on Your claim is submitted with a routine diagnosis, then all Covered Expenses: 1. on that claim and 2. from the same Qualified Practitioner with the same date of service, regardless of diagnosis, will be payable as a Wellness Benefit. **X-rays and Lab Tests**: All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit. **Mammograms, pap smears, PSA tests, endoscopic surgeries (e.g. colonoscopies**), **vision exams and hearing exams**: Payable under separate benefits as shown later in this Schedule of Benefits. The Office Visit copay does not apply to this benefit, except as shown.	1-25
Outpatient Hospital Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-27

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	$200 copay per visit, then PPO deductible/100% to PPO coinsurance limit (for PPO and Non-PPO)	This copay is waived if You are admitted to the Hospital from the Emergency Room. This benefit includes Emergency room physician charges and other services provided in the Emergency room. Emergency room treatment is limited to Emergencies, as defined in this Plan.	1-27
Urgent Care Center Benefits	$25 copay per visit, then PPO deductible/100% to PPO coinsurance limit (for PPO and Non-PPO)	Services provided by an Urgent Care Center. Benefits include all Covered Expenses performed during the visit.	1-27
Ambulatory Surgical Center	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-27
X-ray and Laboratory Tests	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit **MRI, MRA, CT Scan, PET Scan** (Office and Outpatient) **PPO**: $100 copay per day, then deductible/100% to coinsurance limit **Non-PPO**: $100 copay per day, then deductible/80% to coinsurance limit	Dental x-rays limited to covered oral surgery or Injury. All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit. The Office Visit copay does not apply to this benefit.	1-28

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Ambulance Service Benefit	PPO deductible/ 100% to the PPO coinsurance limit (for PPO and Non-PPO)	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury. Please refer to the text for more information.	1-28
Pregnancy Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Covered for Employee, spouse and Dependent daughter. Charges mandated by Health Care Reform for pre-natal care and screening for gestational diabetes are payable as shown under the Wellness Benefit. (This does not apply to high risk pregnancy or complications of pregnancy.) Pre-natal ultrasounds covered under X-ray and Lab Test Benefit.	1-28
Newborn Benefits	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	See "Section 3 – Eligibility" for important information on Dependent Coverage.	1-29
Birthing Center Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-30
Extended Care Facility Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Limited to 60 days per Confinement.	1-30

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Home Health Care Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	When Home Health Care is in lieu of a covered Confinement in a Hospital or Extended Care Facility.	1-30
Hospice Care Benefit	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Hospice Care must be in lieu of a covered Confinement in a Hospital or Extended Care Facility.	1-31
Human Organ and Tissue Transplants	**Centers of Excellence**: 100%, deductible and coinsurance waived **Not a Centers of Excellence**: Non-PPO deductible/80% to the Non-PPO coinsurance limit **Travel and Lodging**: 100%, deductible and coinsurance waived	**Tissue and Cornea Transplants**: Paid under the Medical Benefits. (Not payable under these transplant benefits.) Refer to the list of covered transplants in the text. **Living Donors**: Covered only if the recipient is also covered under this Plan. **Travel and lodging**: Limited to $10,000 paid per transplant. (Covered only when a Centers of Excellence is used for the transplant.) Refer to the Human Organ and Tissue Transplant benefit for more information.	1-32
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other Sickness or Injury.		1-33
Other Covered Expenses	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-35

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Services	**Manipulations** PPO: $25 copay per visit, then deductible/100% to coinsurance limit Non-PPO: $50 copay per visit, then deductible/80% to coinsurance limit **Other Covered Expenses** Paid the same as any other Injury or Sickness	Routine and maintenance care is not covered. This benefit applies to manipulations billed by a chiropractor or any other Qualified Practitioner. Other Covered Expenses received in association with the manipulation will be payable as any other Sickness or Injury.	1-35
Physical, Speech, Occupational and Respiratory Therapy	PPO: $25 copay per visit, then deductible/100% to coinsurance limit Non-PPO: $50 copay per visit, then deductible/80% to coinsurance limit		1-35
Outpatient Cardiac Rehabilitation	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Limited to Phase II only. (Phase III is not covered.)	

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Diabetes Supplies and Education	**Supplies:** PPO deductible/ 100% to the PPO coinsurance limit. **Self-Management Education**: PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	**Diabetic Supplies**: The diabetic supplies are covered under the medical plan only if they are not covered under the Prescription Drug Card.	1-36
Allergy Testing and Treatment	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	The Office Visit copay does not apply to this benefit.	1-36
Second Surgical Opinion	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	The Office Visit copay does not apply to this benefit.	1-36
Pre-Admission Testing	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-36

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Vision Exams	**1st each Plan Year** (regardless of diagnosis): 100%, deductible and coinsurance waived (for PPO and Non-PPO) **Additional in the same Plan Year (**regardless of diagnosis**):** PPO deductible/ 100% to the PPO coinsurance limit (for PPO and Non-PPO)	Benefits include routine and non-routine vision exams and eye refractions. For any Covered Person. The Office Visit copay does not apply to this benefit.	1-37
Hearing Exams	**1st each Plan Year** (regardless of diagnosis): PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit **Additional in the same Plan Year** (regardless of diagnosis): PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Benefits include routine and non-routine hearing exams. For any Covered Person. The Office Visit copay does not apply to this benefit.	1-37
Hearing Aids	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Limited to one hearing aid per ear, per lifetime for any Covered Person age 18 and older. Refer to the State Mandated Benefits section of the Plan for additional benefits for hearing aids and/or cochlear implants.	1-37

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Mammograms	**1st each Plan Year** (regardless of diagnosis): PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit **Additional in the same Plan Year (**regardless of diagnosis): PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Benefits include routine and non-routine mammograms. For any covered female person. For the first mammogram per Plan Year only (regardless of diagnosis): If any Covered Expense included on Your claim is submitted, then all Covered Expenses: 1. on that claim and 2. from the same Qualified Practitioner with the same date of service, will be included under this benefit. 3D mammograms are covered. The Office Visit copay does not apply to this benefit.	1-37
Pap Smears and Pelvic Exams	**1st each Plan Year** (regardless of diagnosis): PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit **Additional in the same Plan Year (**regardless of diagnosis): PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Benefits include routine and non-routine pap smears and pelvic exams. For any covered female person. For the first pap smear/pelvic exam per Plan Year only (regardless of diagnosis): If any Covered Expense included on Your claim is submitted, then all Covered Expenses: 1. on that claim and 2. from the same Qualified Practitioner with the same date of service, will be included under this benefit. The Office Visit copay does not apply to this benefit.	1-37

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
PSA Tests and Prostate Exams	**1st each Plan Year** (regardless of diagnosis): PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit **Additional in the same Plan Year (**regardless of diagnosis): PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Benefits include routine and non-routine PSA tests and prostate exams. For any covered male person. For the first PSA test/prostate exam per Plan Year only (regardless of diagnosis): If any Covered Expense included on Your claim is submitted, then all Covered Expenses: 1. on that claim and 2. from the same Qualified Practitioner with the same date of service will be included under this benefit. The Office Visit copay does not apply to this benefit.	1-37

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy, CT colonography)	**1st each Plan Year** (regardless of diagnosis): PPO: 100%, deductible and coinsurance waived Non-PPO: Deductible/80% to coinsurance limit **Additional in the same Plan Year (**regardless of diagnosis): PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit **Fecal DNA Testing (e.g. Cologuard)**: 100%, deductible and coinsurance waived (for PPO and Non-PPO)	Benefits include routine, non-routine and those required due to family history. For any Covered Person. For the first colorectal cancer screening test per Plan Year only (regardless of diagnosis): If any Covered Expense included on Your claim is submitted, then all Covered Expenses: 1. on that claim and 2. from the same Qualified Practitioner with the same date of service, will be included under this benefit. The Office Visit copay does not apply to this benefit.	1-37
Take-Home Medications	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit		1-37
Health Club Reimbursement Benefit	100%, deductible and coinsurance waived	Limited to $120 paid per Covered Person, per Plan Year, not to exceed $240 paid per Covered Family, per Plan Year. For any Covered Person. Weight Watchers is included in this benefit.	1-38

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
State Mandated Benefits	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit Unless shown otherwise in this Plan.	Refer to the State Mandated Benefits section of this Plan for more information.	1-40
Routine Immunizations (State Mandated Benefit)	100%, deductible and coinsurance waived (for PPO and Non-PPO)	Limited to Dependent children under six years of age. Refer to list of covered immunizations in text. This benefit is in addition to any Wellness or Well Child Care benefit that may be part of this Plan. The Office Visit copay does not apply to this benefit.	1-40
TMJ Benefits (State Mandated Benefit)	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Benefits include diagnostic, surgical and non-surgical treatment. The Office Visit copay does not apply to this benefit.	1-40
Dental (Hospital or Ambulatory Surgical Services) (State Mandated Benefit)	PPO: Deductible/ 100% to coinsurance limit Non-PPO: Deductible/80% to coinsurance limit	Applies to: 1) a child under the age of five years, 2) a person with a chronic disability, 3) a person with a medical condition that requires hospitalization for such dental care, or 4) a person with a medical condition that requires general anesthesia, for such dental care. Refer to the State Mandated Benefits for details about this benefit.	1-40

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Blood Lead Tests (State Mandated Benefit)	If these tests are not covered under the Wellness Benefit, they will be paid the same as any other lab test.	For covered Dependent children under six years of age. According to the recommended lead screening methods and intervals set by the rules of the Department of Health and Social Services.	1-40
Limitations and Exclusions	Not Payable	List of exclusions that apply to all Covered Expenses. A service that is normally covered may be excluded when provided with an excluded item.	1-44
Prescription Drug Card **Note**: Excludes those who are eligible for Medicare Part D.	100%, after copay Copays apply per drug/refill, up to the Prescription Drug out-of-pocket limit. (Once the limit is met, no copays will be taken for the rest of that Plan Year.)	**Retail Copays** (30-day supply) Value Priced Generics: $0 (zero) copay Tier 1 (Generic): $10 copay Tier 2 (Formulary): $25 copay Tier 3 (Non-Formulary): $50 copay **Retail Copays** (31 to 90-day supply) Value Priced Generics: $0 (zero) copay Tier 1 (Generic): $20 copay Tier 2 (Formulary): $50 copay Tier 3 (Non-Formulary): $100 copay **Mail Order Copays** (90-day supply) Value Priced Generics: $0 (zero) copay Tier 1 (Generic): $20 copay Tier 2 (Formulary): $50 copay Tier 3 (Non-Formulary): $100 copay **Specialty:** $100 copay per fill. (Limited to a 30-day supply per fill.) **Out-of-Pocket Limits** Individual: $2,000 per Plan Year. Family: $4,000 per Plan Year. These copays are waived for certain diabetic supplies. **Note**: Prescription Drug copays do not apply to the medical out-of-pocket limits.	1-50

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered Expenses are payable, after satisfaction of the deductible, on a Usual, Customary and Reasonable basis at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits

Deductible

The deductible applies to each Covered Person, each Plan Year. Only charges which qualify as a Covered Expense may be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits. (**Note**: **The PPO deductible is separate from the Non-PPO deductible and vice versa**.)

Maximum Family Deductible

The total deductible applied to all Covered Persons in one family, in a Plan Year, is subject to the maximum shown on the Schedule of Benefits. Once Your family reaches this maximum for a Plan Year, no further deductibles will be applied during that Plan Year.

Coinsurance

Benefits are payable at the percentage rate shown on the Schedule of Benefits, after the deductible is satisfied each Plan Year. Benefits are payable for the rest of the Plan Year or up to any Plan maximums, on a Usual, Customary and Reasonable basis, at the percentage rate shown on the Schedule of Benefits.

Copayments or Copays

The copay for a Covered Expense will apply each time that expense is received. The amount of the copay varies by the type of service provided. All copays are shown on the Schedule of Benefits.

Out-of-Pocket Limit

The amount You must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of the deductible, coinsurance and copays if applicable, embedded dental, embedded vision and embedded prescription drug. When the out-of-pocket limit has been met for a Covered Person or family, the Plan will pay 100% of Covered Expenses for the rest of the Plan Year. **(Note: The PPO out-of-pocket limit is separate from the Non-PPO out-of-pocket limit and vice versa**.)

This limit does not apply to:

1. Penalties for failure to comply with the Prior Authorization requirements; or

2. Prescription drug copays. (There is a separate out-of-pocket limit for prescription drugs, as shown in the Prescription Drug Card section of the Schedule of Benefits.)

PRIOR AUTHORIZATION REQUIREMENTS

HOW THE PROGRAM WORKS

When You call UM for authorization, You will be asked the following questions:

1. Group name and number
2. Name of Employee
3. Employee's participant #
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once Prior Authorization is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new Prior Authorization must be made if: You do not receive the treatment within 30 days of the scheduled date; You use a different facility or physician; or You are admitted for a different reason.

PRIOR AUTHORIZATION REQUIREMENTS

You or Your Qualified Practitioner are required to notify UM for authorization prior to receiving certain types of health care. The services that require Prior Authorization are listed on the Schedule of Benefits. **If You are required to provide Prior Authorization and fail to do so, benefits may be reduced or denied.**

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY

If the provider is required to obtain Prior Authorization and it is not provided, You will not be subject to the non-compliance penalty. Your treatment will be reviewed when a claim is received.

If You are required to obtain Prior Authorization and it is not provided, Your treatment will be reviewed when a claim is received. If it is determined to be a Covered Expense, benefits that are otherwise payable will be reduced as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit.

If Your treatment is not a Covered Expense, no benefits will be payable under the Plan.

NOTICE SECONDARY COVERAGE WAIVER

If this Plan is secondary to another medical plan that also covers you, Prior Authorization will not be required.

CASE MANAGEMENT

Case management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for the following services or supplies furnished by a Hospital are payable as shown on the Schedule of Benefits.

Room and Board
Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the Hospital, unless necessary due to Your Sickness or Injury or the Hospital offers only private rooms for the services provided, such as birthing rooms.

Hospital Miscellaneous Charges
Charges made by the Hospital on its own behalf for services and supplies furnished for Your treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests; and

2. Professional services of an anesthesiologist.

QUALIFIED PRACTITIONER BENEFITS

Benefits are payable as shown on the Schedule of Benefits and include charges made by a Qualified Practitioner for the following services:

1. Qualified Practitioner office visits;

2. Inpatient Hospital visits by a Qualified Practitioner;

3. Outpatient medical services by a Qualified Practitioner;

4. Surgical services. A surgical procedure, including pre- and post-operative care and subsequent care for surgeries performed in the outpatient department of a Hospital or Ambulatory Surgical Center. Diagnostic x-ray and laboratory services related to a covered surgery are also a Covered Expense under this benefit.

   Subsequent surgical procedures (i.e. suture or cast removal), which are normally considered part of the Usual, Customary and Reasonable fee for the initial surgery will only be considered for payment as a separate service when performed by a Qualified Practitioner other than the operating surgeon.

5. Assistant surgeon services. The services of a second surgeon or a licensed surgical assistant are a Covered Expense only when the services are necessary for the safe and effective performance of a covered surgical procedure;

6. Administration of anesthesia. Payable only if they are not included in the global surgical fee; and

7. Services provided by an anesthesiologist or anesthetist to monitor the Covered Person's vital signs.

ORAL SURGERY BENEFIT

The following oral surgical procedures are covered, including necessary x-ray and laboratory tests:

1. Excision of partially or completely unerupted, impacted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;

3. Surgeries required to correct Accidental Injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;

4. Reduction of fractures and dislocations of the jaw;

5. External incision and drainage of cellulitis;

6. Incision of accessory sinuses, salivary glands or ducts;

7. Frenectomy (the cutting of the tissue in the midline of the tongue);

8. Functional osteotomy;

9. Osseous surgery;

10. Gingivectomy (the excision of diseased gum tissue to eliminate infection);

11. Gingival flap surgery;

12. Periodontal surgery;

13. Grafting;

14. Apicoectomy (the excision of the apex of the tooth root);

15. Alveolectomy (the leveling of the structures supporting the teeth when performed for reasons other than preparation for dentures);

16. Treatment required to repair and restore natural teeth damaged due to Injury, including dental implants. Damage resulting from biting or chewing will not be considered an Injury. Subsequent treatment to an Injured tooth after the initial treatment is not covered. (Note: A sound, natural tooth is one that is organic, not manufactured. Therefore, bridges, implants, crowns and dentures are not natural teeth. Any service for or in connection with the restoration and repair are not covered under this Plan.)

17. Orthodontia, occlusal adjustments and dental restorations when required to repair and restore the function of natural teeth damaged due to Injury;

18. Orthognathic surgery when required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment;

19. Dental exams performed in preparation for a covered oral surgery;

20. Extraction of natural teeth;

21. Dental implants; and

Oral Surgery Benefit – continued

22. The Plan will also cover the following services if they are received within 18 months of the date that the natural teeth were extracted:

    a. The initial replacement of the extracted natural teeth. (Dental implants are covered under this Plan.)

    b. The replacement of previously existing fixed bridgework if replacement is required due to the extraction of one or more natural teeth that are:

        i. Adjacent to the fixed bridgework, **or**

        ii. Abutment teeth supporting the existing bridgework,

    c. The replacement of previously existing partial removable dentures:

        i. If replacement is required due to the extraction of one or more natural teeth, **and**

        ii. The existing partial denture is no longer serviceable and cannot be made serviceable.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Covered Expenses include but are not limited to the following:

All Covered Persons

(**Note**: Vision and hearing exams are payable under separate benefits, as shown on the Schedule of Benefits.)

1. Preventive medicine visits (wellness exams);
2. All standard immunizations recommended by the American Committee on Immunization Practices. Immunizations for foreign travel are also covered under this benefit. Benefits are payable for the Zoster (shingles) vaccine for any Covered Person, without age or frequency limitations.

Screening/Services For All Covered Persons at Appropriate Ages

(**Note**: Colonoscopies are payable under a separate benefit, as shown on the Schedule of Benefits.)

1. Elevated cholesterol and lipids;
2. Certain sexually transmitted diseases and HIV (includes counseling);
3. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
4. High blood pressure;
5. Diabetes;
6. Depression;
7. Screening/counseling for obesity (adults and children);
8. Cardiac calcium scans.

For Women

(**Note**: Pap smears, pelvic exams and mammograms are payable under a separate benefit, as shown on the Schedule of Benefits.)

1. Genetic testing and counseling for BRCA breast cancer gene;
2. Screening for gonorrhea, chlamydia, syphilis;
3. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;

Wellness Benefit – continued

4. Instructions to promote and help with breast feeding;
5. Screening for osteoporosis;
6. Counseling for those at high risk for breast cancer for chemoprevention;
7. Gynecological exams;
8. Routine pre-natal care;
9. Routine gestational diabetes screening;
10. Human papillomavirus (HPV) DNA testing for any covered female person;
11. Counseling for sexually transmitted infections (provided annually);
12. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
13. Breastfeeding support, supplies and counseling in conjunction with each birth. Benefits include comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and charges for the rental or purchase of breastfeeding equipment. Retail and over-the-counter equipment, supplies, sales tax and shipping charges are payable under the Wellness Benefit at the In-Network (PPO) level of benefits. (A prescription is not required.) Limited to one breast pump per delivery. The below criteria is applied to the purchase of breast pumps:

    a. **Hospital Grade Breast Pump**: Rental Only:
    Hospital Grade Breast Pumps (heavy duty designed for multiple users), and the personal use attachment kit, are covered for a Covered Person who is a lactating mother when the Covered Person obtains the Hospital grade breast pump within the first two months (60 days) following delivery and their infant has one or more of the following criteria:

        i. Hospitalized newborn infant; or
        ii. Congenital malformations or genetic abnormalities impacting feeding (e.g. cleft lip and palate, Down's Syndrome).

    b. **Personal Use Double Electric Breast Pump**:
    High quality, personal use double electrical breast pumps have been shown to be as effective as Hospital grade pumps in outpatient settings for breast feeding females. This includes mothers with maternal infant separation for work or school and no other identified lactation risk factors.

    A personal use double electrical pump may be covered for the Covered Person with the following criteria:
        i. The woman is a lactating mother; and
        ii. The Covered Person should obtain the breast pump within one year (365 days) of delivery.

14. Screening and counseling for interpersonal and domestic violence (provided annually);
15. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), such as insertable vaginal devices, injections and administration, devices (e.g. IUD, implants) including insertion and removal, sterilizations (for any covered female person), patient education and related office services. (Note: Birth control pills and patches may be covered under the Drug Card. Birth control that is not covered under the Drug Card will be covered under the Medical Plan).

For Men

(**Note**: PSA tests are payable under a separate benefit, as shown on the Schedule of Benefits.)

1. Screening for abdominal aortic aneurysm;
2. Human papillomavirus (HPV) DNA testing;
3. Counseling for sexually transmitted infections (provided annually);
4. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);

Wellness Benefit – continued

5. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), including sterilizations (for any covered male person), patient education and related office services;
6. Screening and counseling for interpersonal and domestic violence (provided annually).

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis. (Note: Blood lead tests that are not covered under this benefit are payable as shown under the State Mandated Benefits section of this Plan);
6. Preventive/routine oral fluoride supplements prescribed for Dependent children ages six months to five years old whose primary water source is deficient in fluoride;
7. Third party exams for Dependent children (as such children are defined in this Plan.) Limited to routine exams required for school, sports and camps only. Limited to one third party exam per Plan Year.

Please visit the following links for additional information:

https://www.healthcare.gov/preventive-care-benefits/
https://www.healthcare.gov/preventive-care-children/
https://www.healthcare.gov/preventive-care-women/

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient Hospital services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of Your Sickness or Injury;

2. Diagnostic x-rays and laboratory services;

3. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by Your attending Qualified Practitioner; and

4. Emergency room charges, but **only** if incurred due to:

    a. Emergency Accident treatment,
    b. a surgical procedure, or
    c. treatment of a Sickness that is a medical Emergency.

URGENT CARE CENTER BENEFIT

Charges for Covered Expenses provided by an Urgent Care Center are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by a free standing surgical facility or Ambulatory Surgical Center, on its own behalf, for surgical procedures performed and for Hospital miscellaneous services provided in the facility.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A Qualified Practitioner must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered Injury or oral surgery. Cardiac calcium scans are payable as any other Sickness or Injury. (Routine cardiac calcium scans are payable under the Wellness Benefit.)

AMBULANCE SERVICE BENEFIT

Charges for licensed ground ambulance service to the nearest facility that is equipped to treat Your Sickness or Injury. Licensed air ambulance to the nearest facility equipped to treat Your Sickness or Injury, but only if such air transport is required for the treatment of Your Sickness or Injury. Licensed ambulance transport between medical facilities, but only if You cannot be treated safely and effectively in the facility where You are confined and Your Sickness or Injury requires the attendance of medical professionals during Your transport. In this case, benefits are limited to the cost of transportation to the nearest facility equipped to treat Your Sickness or Injury. If You need care that is not available in a local Hospital, transport to the nearest Hospital that can provide the care is covered. If You require care that is not available by ground ambulance, air ambulance service to the nearest Hospital that can provide the care is covered.

Ambulance transport that is primarily for the convenience of the patient, a family member or the Qualified Practitioner is not a Covered Expense.

PREGNANCY BENEFIT

Pregnancy is a Covered Expense for any covered female person and payable as shown on the Schedule of Benefits. Complications of Pregnancy are payable, for any covered female person, as any other covered Sickness at the point the complication sets in.

Hospital and Qualified Practitioner services in performing therapeutic abortions are Covered Expenses. Complications of abortions are payable for any covered female person at the point the complication sets in.

Nurse- midwife services related to prenatal care, labor and delivery and postpartum care performed by either: 1) a registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Mid-wives and the State of Wisconsin; or 2) a licensed nurse certified as a nurse-midwife in the state in which he or she practices. Except for Emergencies, You must receive the nurse-midwife services in a health care facility approved for the practice of nurse-midwifery by the state in which it is located. (**Note**: Midwife labor and delivery services outside of the Hospital are not covered unless the facility is approved by the Plan and meets the definition of Qualified Treatment Facility.)

Childbirth education classes (e.g. Lamaze) are not covered under this Plan.

Amniocentesis or ultrasounds performed to alleviate anxiety or to determine the gender of the fetus are not covered under this Plan.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 72 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Pregnancy Benefit - continued

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 72-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 72 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, You may be required to obtain Prior Authorization. For information on Prior Authorization, contact Your Plan Administrator.

Special Services – When a Pregnancy Exists

The Plan covers amniocentesis, genetic testing, genetic counseling and chromosome studies if any of the following conditions exist:

1. The pregnant Covered Person is age 35 or older;

2. The pregnant Covered Person or her spouse has a family history of a highly disabling hereditary disorder or has previously had a child with such a disorder;

3. The pregnant Covered Person has previously experienced a miscarriage or stillbirth;

4. The pregnant Covered Person is a known carrier of a genetic abnormality or disease; or

5. The pregnant Covered Person was exposed, before or during pregnancy, to diseases or chemicals strongly linked to birth defects, or the pregnant Covered Person's spouse was exposed to such disease or chemicals before the pregnancy began.

Special Services – When No Pregnancy Exists

The Plan covers genetic testing, genetic counseling and chromosome studies that are expected to reveal new information relevant to the decision to have a child if any of the following conditions exist:

1. The Covered Person or spouse has a family history of a highly disabling hereditary disorder;

2. The Covered Person or her spouse is a known carrier of a genetic abnormality or disease;

3. The Covered Person or her spouse has previously had a child with a genetic disorder, abnormality or disease; or

4. The Covered Person has had multiple miscarriages or stillbirths.

NEWBORN BENEFITS

This benefit does **not** apply unless You enroll Your newborn Dependent within 60 days of the date of birth. See the "Eligibility" section of this booklet for more information.

A newborn child of a Covered Employee is covered during the first 60 days of life. Dependent coverage **must** be in force for coverage to continue past the first 60 days of life. If Dependent coverage is not in force at the end of the 60 days, the child's coverage will terminate immediately.

However, coverage may still be effective on the child's date of birth if the following conditions are met: Coverage is applied for within 12 months of the child's date of birth and all back contributions due plus 5 ½% interest are paid.

Well Newborn

Covered Expenses incurred during the period of the mother's hospitalization following delivery. Hospital charges for nursery room, board and care; the Qualified Practitioner's charge for circumcision of a male newborn child; and the Qualified Practitioner's charges for routine examination of the newborn child before release from the Hospital.

Sick Newborn

Covered Expenses also include expenses incurred for the following: Injury or Sickness; necessary care and treatment for premature birth; medically diagnosed birth defects and abnormalities; and surgery to repair or restore any body part necessary to achieve normal body functioning. Covered Expenses do **not** include Expenses Incurred for plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to Injury, infection or other disease of the involved part; or

2. Congenital disease or anomaly of a covered Dependent child which resulted in a functional defect.

BIRTHING CENTER BENEFIT

Services and supplies provided in a Birthing Center for prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

EXTENDED CARE FACILITY BENEFIT

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

HOME HEALTH CARE BENEFIT

Home Health Care services are provided when such services are determined to be Medically Necessary.

Covered Expenses may include:

1. Home visits, instead of visits to the Qualified Practitioner's office that do not exceed the Usual, Customary and Reasonable charge for the same service in a Qualified Practitioner's office;
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period;
3. Nutrition counseling provided by or under the supervision of a qualified dietician, or other Qualified Practitioner, if applicable;
4. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a qualified therapist, or other Qualified Practitioner, if applicable; and
5. Medical supplies, drugs or medication prescribed by a Qualified Practitioner and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a qualified therapist, qualified dietician, or other Qualified Practitioner, if applicable.

Exclusions

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following services or supplies:

1. Homemaker or housekeeping services;
2. Supportive environment materials such as handrails, ramps, air conditioners and telephones;
3. Services performed by family members or volunteer workers;
4. "Meals on Wheels" or similar food service;
5. Separate charges for records, reports or transportation;
6. Expenses for the normal necessities of living such as food, clothing and household supplies; or
7. Legal and financial counseling services, unless otherwise covered under this Plan.

HOSPICE CARE BENEFIT

1. Room and board and related services and supplies;

2. Part-time nursing care by or supervised by a registered nurse (R.N.);

3. Medical social services for You and Your Immediate Family under the direction of a Qualified Practitioner, including:

    a. assessment of social, emotional and medical needs, and the home and family situation,
    b. identification of the community resources available and assisting in obtaining those resources;

4. Dietary counseling;

5. Consultation and case management services by a Qualified Practitioner;

6. Physical or occupational therapy;

7. Home Health Care and related supplies;

8. Part-time home health aide service; and

9. Medical supplies, drugs and medicines prescribed by a Qualified Practitioner.

Hospice care must be furnished in a Hospice Facility or by a Hospice Care Agency in Your home. Hospice Care must be instead of a covered Confinement in a Hospital or Extended Care Facility. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less. For Hospice Care only, Your immediate family is Your parent, spouse and Dependent children.

Limitations

Hospice care benefits do **not** include: private or special nursing services; a Confinement not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; services by a licensed pastoral counselor to a member of his congregation; bereavement counseling or respite care.

HUMAN ORGAN AND TISSUE TRANSPLANTS

The following human organ or tissue transplants are payable as shown on the Schedule of Benefits when the transplant is provided from a human donor to a living human transplant recipient and the attending Qualified Practitioner certifies that the transplant is Medically Necessary.

1. Bone marrow transplants, when not experimental or investigational. The Covered Person must request in advance, from the Plan, a determination as to whether a bone marrow transplant is covered or is excluded as experimental or investigational;

2. Cornea transplants;

3. Arteries or veins;

4. Heart transplants;

5. Heart lung transplants (combined procedures);

6. Kidney transplants;

7. Liver transplants;

8. Lung transplants;

9. Pancreas transplants;

10. Kidney pancreas transplants (combined procedures);

11. Small bowel transplants; and

12. Any other tissue or organ transplant that may be covered elsewhere in this Plan.

    NOTE: THE PLAN SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS YOU ARE AWARE OF THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR YOU. .

Living donors: Such donors are covered only if the recipient is also a Covered Person under this Plan.

Travel and Lodging: Travel expenses for the Covered Person and the person (two persons if the patient is a minor) who accompany the Covered Person to and from the Centers of Excellence transplant facility are covered under this Plan. Lodging expenses at or near the Centers of Excellence transplant facility for the Covered Person and the person(s) who accompany the Covered Person to the Centers of Excellence transplant facility are covered under this Plan. (Travel and lodging expenses are covered only when a Centers of Excellence is used for the transplant.)

When both the recipient and donor are covered by this Plan, each is entitled to benefits under the Plan.

When only the recipient is covered by the Plan, both the donor and the recipient are entitled to the benefits of the Plan. The donor's benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the Plan.

When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient.
Revised 7/1/17

If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue. However, other costs related to the evaluation and procurement are covered for a recipient who is covered under this Plan.

The Plan does not cover animal to human transplants or artificial or mechanical devices designed to replace human organs.

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

The following expenses incurred by You during a plan of treatment for a psychological disorder, chemical dependence or alcoholism are payable as stated below:

1. Charges made by a Qualified Practitioner;

2. Charges made by a Hospital;

3. Charges made by a Qualified Treatment Facility; and

4. Charges for nutritional counseling when it is part of an approved treatment plan prescribed by a Qualified Practitioner, provided by a certified or registered dietician and necessary for the effective treatment of a life-threatening Sickness (e.g. anorexia nervosa).

Inpatient Benefits

Covered Expenses while confined as a registered bed patient in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits.

Transitional Treatment Benefits

Covered Expenses for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services provided by a residential treatment program; and services provided in a day treatment program.

Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Covered Expenses for outpatient treatment received while not Confined in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits.

Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations

Benefits do **not** include:

1. Treatment of nicotine habit or nicotine addiction. (Note: Certain services may be covered as shown under the Other Covered Expenses section of this Plan.)

2. Marriage counseling; or

3. Court ordered examinations or counseling.

OTHER COVERED EXPENSES

These other Covered Expenses are payable as shown on the Schedule of Benefits:

1. Chiropractic Services. Manipulations and other services billed by a chiropractor or any other Qualified Practitioner for the treatment of an Injury or Sickness. The following services and supplies are not covered under this benefit: a) routine and maintenance care, b) massage therapy services, c) supplies or counseling in connection with any supplies such as vitamins, herbs, nutritional supplements, cervical pillows, heel lifts and lumbar rolls, or d) orthotic devices, unless custom made and prescribed by a Qualified Practitioner.

2. Treatment by a licensed: physical therapist; speech therapist; respiratory therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an Injury or Sickness, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders.

3. Charges for outpatient cardiac rehabilitation. Limited to Phase II only. (Phase III is not covered.)

4. Aquatic therapy. Benefits apply per designation (e.g. physical therapist, occupational therapist respiratory therapist). If billed by a physical, occupational or respiratory therapist, benefits are payable as shown under the therapy section of the Schedule of Benefits. All other providers are payable based on the Covered Expenses that are billed for.

5. Outpatient radiation therapy; chemotherapy.

6. Blood and blood plasma.

7. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for nursing care ordered by Your attending Qualified Practitioner. The nurse must not ordinarily reside in Your home or be a Family Member.

8. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

9. Rental/Purchase of Equipment:

    a. Oxygen and rental of equipment for its administration; rental of equipment to treat respiratory paralysis,

    b. Rental up to the total purchase price or when approved by the Plan purchase of a wheelchair, Hospital bed, respirator or other durable medical equipment. The equipment must be needed for therapeutic treatment, be able to withstand repeated use, primarily and customarily used to serve a medical purpose, and not generally useful to a person except for the treatment of an Injury or Sickness. Replacement devices are covered, unless required due to negligence or abuse of the device. Functional repair expenses are covered, unless they are required due to negligent use or abuse of the equipment. Routine maintenance expenses are not covered. Convenience items, as determined by the Plan, are not covered. Unless approved by the Plan benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

10. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices are covered, unless required due to negligence or abuse of the device. Functional repairs are covered, unless required due to negligent use or abuse of the device. Routine maintenance expenses are not covered. Dental appliances are not covered.

Other Covered Expenses – continued

11. Wigs and other treatments for hair loss. Covered only in the case of sudden onset baldness that is the result of a covered Sickness, Injury or medical treatment and it is sufficiently extensive to significantly alter Your appearance.

12. The installation and use of an insulin infusion pump. Diabetic equipment and supplies used in the treatment of diabetes, if they are not covered under the Prescription Drug Card. Diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year and the pump must be in use for 30 days before the initial purchase.

13. Special supplies when prescribed by Your attending Qualified Practitioner and necessary for the continuing treatment of a Sickness or Injury, such as:

    a. catheters,
    b. colostomy bags, belts and rings,
    c. flotation pads,
    d. needles and syringes,
    e. custom molded orthotic devices. (Over-the-counter orthotics are not covered.)
    f. casts, splints, surgical dressings, trusses, braces and crutches,
    g. oxygen and other gases,
    h. surgical stockings (e.g. Jobst stockings),
    i. initial contact lenses or eyeglasses following cataract surgery.

    Not Covered: Equipment or supplies to prevent Injury or to facilitate participation in physical activity or sports.

14. Allergy testing and treatment, if it meets the standards of the American Academy of Allergy, Asthma and Immunology (AAAAI). Covered Expenses include initial diagnostic evaluations, diagnostic tests to determine the cause of an allergy and injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis. **The Plan does not cover**: neutralization testing and treatment; repeated intradermal testing, unless documentation indicates the need for continued testing, skin test end-point titration for evaluating the effectiveness of immunotherapy or food allergy therapy. (Food allergy testing is covered, but not therapy. Sublingual antigen drops are payable as any other Sickness or Injury.)

15. Infertility. Limited to services performed exclusively to diagnose the cause(s) of infertility. Once a diagnosis has been rendered, no further diagnostic tests are covered, unless they are expected to reveal another clinical cause for infertility. The treatment of infertility is not a Covered Expense.

    Benefits include surgical procedures necessary to repair or restore a malformed or malfunctioning body part or process found to be the cause of infertility, in order to enable natural conception. The Plan does not cover: Reversals of tubal ligations, vasectomies, artificial means to achieve pregnancy or other treatment of infertility.

16. Charges incurred for a second surgical opinion. You may go to a Qualified Practitioner of Your choice. Generally, the Qualified Practitioner may not be in practice with the practitioner who gave the initial opinion and may not perform the procedure.

17. Pre-admission testing required in connection with an inpatient Hospital admission for surgery.

18. Hospital admission kits.

Other Covered Expenses – continued

19. Routine and non-routine vision services. Benefits include, but are not limited to: routine vision exams and related refraction charge, diagnosis and treatment of eye pathology, eye surgery for treatment of a Sickness or Injury of the eye, the initial lens after cataract surgery; therapeutic contact lenses for treating a Sickness or Injury, such as keratoconus and the initial artificial eye to replace an eye loss due to Injury or Sickness. **The Plan does not cover**: a) non-prescription lenses, b) vision therapy (orthoptics), c) refractive eye surgery, such as radial keratotomy; d) eyeglasses or contact lenses after cataract surgery, other than the initial pair; or e) expenses for or related to an artificial eye, other than the initial artificial eye.

20. Routine and non-routine hearing-related services. Benefits include: a) routine hearing exams, b) diagnostic tests to establish or confirm a hearing loss and determine the cause, c) treatment of hearing pathology caused by an Injury or Sickness, d) surgery to repair malformed or malfunctioning hearing-related structures, e) Hearing aids for any Covered Person age 18 and older and f) Cochlear implants, but only if the implant is authorized in advance by the Plan Administrator and the Employer and as shown under the State Mandated Benefits. **The Plan does not cover**: a) hearing exams or tests for the fitting of a hearing aid or device, b) hearing aids and devices, even when part of a cochlear implant evaluation, **except** as shown on the Schedule of Benefits or c) services associated with prescribing hearing aids or devices, **except** as stated under the State Mandated Benefits. (**Note**: Hearing aids for any Covered Person age 18 and older are payable as shown on the Schedule of Benefits.)

21. Non-routine immunizations and injections. (Routine immunizations are payable as shown under the Wellness Benefit and under the Stated Mandated Benefits.)

22. Treatment and services required to obtain a prescription for smoking cessation drugs. The Medical Plan does not cover the drugs or any other treatment of nicotine addiction. (The drugs may be covered under the Prescription Drug Card.)

23. Routine and non-routine mammograms. For any covered female person. 3D mammograms are covered.

24. Medically Necessary genetic testing for BRCA breast cancer gene. Benefits will be payable as any other Sickness or Injury. (Routine genetic testing for BRCA are payable under the Wellness Benefit.)

25. Routine and non-routine pap smears and pelvic exams. For any covered female person.

26. Routine and non-routine PSA tests and pelvic exams. For any covered male person.

27. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy, CT colonography). Includes routine, non-routine and those requested due to family history. Fecal DNA testing (e.g. Cologuard) is covered as shown on the Schedule of Benefits.

28. Take home supplies and medications dispensed by the Hospital at the time of Hospital discharge for use at home. This includes discharge from the Emergency Room or an Urgent Care Center.

29. Home testing and monitoring supplies and equipment, except those prescribed for the treatment of diabetes mellitus and infant apnea.

30. Nutritional counseling and education visits by a registered dietician.

31. Debridement of nails by CPT codes 11720 and 11721.

32. Treatment of complications resulting from services that are not covered under this Plan.

Other Covered Expenses – continued

33. Health Club Reimbursement Benefit. Fees for health clubs, fitness programs/classes and Weight Watchers programs are payable as shown on the Schedule of Benefits.

34. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

    a. reconstruction of the breast that was removed,
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
    c. prostheses to replace the breast that was removed, and
    d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

    Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the Plan.

35. Prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems. The Plan covers food substitutes used for enteral nutrition when they are the only source of nutrition and the need for such food substitutes is medically documented.

36. Qualifying clinical trials as defined below, including routine patient care costs as defined below incurred during participation in a qualifying clinical trial for the treatment of:

    Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

    Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

    Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

    Routine patient care costs for qualifying clinical trials may include:
    1. Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
    2. Covered health services required solely for the administration of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
    3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

    Routine costs for clinical trials do not include:
    1. The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;
    2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
    4. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

Other Covered Expenses – continued

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that meets any of the following criteria in the bulleted list below:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. National Institutes of Health (NIH), including the National Cancer Institute (NCI);
    b. Centers for Disease Control and Prevention (CDC);
    c. Agency for Healthcare Research and Quality (AHRQ);
    d. Centers for Medicare and Medicaid Services (CMS);
    e. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veteran's Administration (VA);
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
4. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The plan sponsor may, at any time, request documentation about the trial; or
5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

STATE MANDATED BENEFITS

These State mandated benefits are covered subject to the deductible and coinsurance of the Plan, unless shown otherwise on the Schedule of Benefits:

1. Immunizations for any covered Dependent child from birth to the age of six years are payable as shown on the Schedule of Benefits. **This benefit is in addition to any Wellness or Well Child Care Benefit that may be part of this Plan**. Including, but not limited to, the following immunizations:

    a. Diphtheria,
    b. Pertussis,
    c. Tetanus,
    d. Polio,
    e. Measles,
    f. Mumps,
    g. Rubella,
    h. Hemophilus influenza B,
    i. Hepatitis B.,
    j. Varicella.

2. Temporomandibular joint (TMJ) diagnostic services and surgical and non-surgical treatment. Benefits include appliances and therapy and steroid joint injections for any jaw joint problem, including and temporomandibular joint disorder, craniomaxillary or craniomandibular disorder or other conditions of the jaw joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof.. **This Plan does not cover the following services**: a) services that are unproven or unconventional, b) orthodontic (e.g. braces) and orthognathic treatment for changing Your bite, c) occlusal adjustment or modification of a dental surface to change Your bite, d) restorative therapy or prosthodontic treatment (e.g. use of crowns and bridges to balance the bite), e) Ultrasonic treatment, electrogalvanic stimulation, iontophoresis and biofeedback, f) transcutaneous electrical nerve stimulation (TENS), g) nutritional counseling and home therapy programs, h) services to treat a chronic condition for which there is no reasonable expectation of a prompt and predictable improvement in Your health status or i) services that continue after You have reached the expected state of improvement, resolution or stabilization of Your health condition.

3. Services of a Hospital or Ambulatory Surgical Center due to dental care. Anesthetics related to the dental care will also be covered. To be a Covered Expense the services must be provided to:

    a. a child under the age of five years,
    b. a person with a chronic disability,
    c. a person with a medical condition that requires hospitalization for such dental care, or
    d. a person with a medical condition that requires general anesthesia, for such dental care.

4. Blood lead tests for covered Dependent children under the age of six years, if such tests are not covered under the Wellness Benefit. Payable as shown on the Schedule of Benefits. Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.

5. Hearing aids, cochlear implants and related treatment for a covered Dependent child under the age of 18 years old, if the child is certified as deaf or hearing impaired by a Qualified Practitioner or audiologist. Covered Expenses include:

    a. the cost of hearing aids and cochlear implants that are prescribed by a Qualified Practitioner or audiologist, in accordance with accepted professional medical or audiological standards,

b. the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices,
c. One hearing aid per ear every three Calendar Years.

6. Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and non-intensive-level services.

   Intensive-level services means evidence-based behavioral therapies that are designed to help a Covered Person with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

   Non-intensive-level services means evidence-based therapy that occurs after the completion of treatment for intensive-level services or, for a Covered Person who has not and will not receive intensive-level services, evidence-based therapy that will improve the Covered Person's condition.

   Intensive-Level Services

   Benefits are provided for evidence-based behavioral intensive-level therapy for a Covered Person with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the Covered Person when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

   a. Based upon a treatment plan developed by a Qualified Practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,

   b. Implemented by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals,

   c. Provided in an environment most conducive to achieving the goals of the Covered Person's treatment plan,

   d. Included training and consultation, participation in team meetings and active involvement of the Covered Person's family and treatment team for implementation of the therapeutic goals developed by the team,

   e. Commenced after a Covered Person is two years of age and before nine years of age,

   f. The Covered Person is directly observed by the Qualified Practitioner at least once every two months.

   Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the Covered Person, regardless of payor, may be applied to the required four years.

   The Plan may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for autism spectrum disorders prior to age nine.

Travel time for Qualified Practitioners, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for a Covered Person with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to a Covered Person by a Qualified Practitioner, professional, therapist or paraprofessional in either of the following conditions:

a. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment,

b. To a Covered Person who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Covered Person's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

a. Based upon a treatment plan developed by a Qualified Practitioner, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,

b. Implemented by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessional,

c. Provided in an environment most conducive to achieving the goal of the Covered Person's treatment plan,

d. Included training and consultation, participation in team meetings and active involvement of the Covered Person's family in order to implement the therapeutic goals developed by the team,

e. Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Travel time for Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan will notify the Covered Person (or their authorized representative) if the level of treatment is transitioning from intensive-level services to non-intensive-level services. The notice will indicate the reason for the transition that may include any of the following:

a. The maximum four-year limit has been met,

b. Intensive-level services are no longer supported by the documentation provided by the Qualified Practitioner,

c. The Covered Person no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

Intensive-level and non-intensive-level services include, but are not limited to speech, occupational and behavioral therapies.

<u>The following services are not covered under the autism spectrum disorders</u>:

a. Acupuncture,
b. Animal-based therapy, including hippotherapy,
c. Auditory integration training,
d. Chelation therapy,
e. Child care fees,
f. Cranial sacral therapy,
g. Custodial or respite care,
h. Hyperbaric oxygen therapy,
i. Special diets or supplements,
j. Pharmaceuticals and durable medical equipment.

MEDICAL LIMITATIONS AND EXCLUSIONS

This Plan does **not** provide benefits for:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine, ayurveda and ayruvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, herbal therapy, vitamin therapy, hypnotherapy, guided imagery; meditation; aromatherapy; relaxation techniques; iridology; massage therapy; or

2. Acupuncture; acupressure.

DENTAL

1. **Dental care** or treatment, except as specifically described;

2. **Subsequent treatment to an Injured tooth,** after the initial treatment;

3. **Orthodontia, occlusal adjustments, or dental restorations,** unless required to repair and restore the function of a natural tooth that is injured;

4. **Replacement of crowns, bridges, partial or full dentures or implants,** except as stated under the Oral Surgery benefit;

5. **Orthognathic surgery**, unless required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment;

6. **Behavior modification therapy or symptomatic care,** such as nutritional counseling and home therapy programs, except as shown as covered elsewhere in this Plan; or

7. **Any service that is directed at improving the appearance of a tooth** and that does not restore the function of an injured tooth, such as, bleaching.

DRUGS

1. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a** Qualified Practitioner **(OTC - over the counter)**. OTC items specifically stated in this plan as a Covered Expense will be covered. When OTC items are provided as a necessary part of a Covered Expense incurred in a Qualified Practitioner's office, Hospital or other facility it will be covered; or

2. Charges for **prescription drugs**, except when not covered by the Employer's Prescription Drug Card and not excluded under any other provision of this Plan.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

   a. items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials, unless identified as a covered service elsewhere in this Plan. (This exclusion does not apply to investigational new drugs which have reached a Phase 3 clinical testing for the treatment of HIV infection.)

   b. items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

   c. items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

   d. items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

   Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in OncologyTM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

   If You have a life threatening condition (e.g. likely to cause death within one year), the Plan may provide coverage for a treatment that would otherwise be excluded under this provision. The Plan reserves sole discretion to make this determination. Such coverage will only be approved if a treatment is provided under a specific research protocol that meets standards equal to those of the National Institutes of Health and has shown promise in limited use.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to Injury, infection or other disease of the involved part is a Covered Expense when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;

2. Any charges for, relating to or resulting from **sex change operations**;

3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;

4. Treatment or services for **weight control or reduction,** except as specifically stated for preventive counseling. Treatment includes, but is not limited to: nutritional or diet supplements; dietary or nutritional counseling (except as stated under the Psychological Disorders, Chemical Dependence and Alcoholism benefit and under the Other Covered Expense); individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; physical fitness programs. (Note: Certain services are covered as shown under the Health Club Reimbursement Benefit.) and

5. Treatment of **obesity or morbid obesity or for weight reduction.**

PROVIDERS

1. Any service or supply:

    a. provided while You are **not under the regular care of a Qualified Practitioner**,
    b. **not authorized or prescribed by a Qualified Practitioner**, or
    c. authorized or prescribed by a Qualified Practitioner, but **excluded under this Plan**;

2. Services provided by a **person who ordinarily resides in Your home** or who is a Family Member;

3. **Telephone, computer or Internet consultations** between You and any provider. Completion of claim forms or forms necessary for Your return to work or school. Any appointment You did not attend; charges for copying and providing medical or any other type of information in support of a claim;

4. **Private duty nursing** while in a Hospital or other Qualified Treatment Facility. (**Note**: Outpatient private duty nursing is a Covered Expense.)

5. Charges for a **standby surgical team**, unless surgery is actually performed; or

6. **Services of a second surgeon or surgical assistant**, unless required for the safe and effective performance of a covered surgical procedure.

REPRODUCTION

1. **Elective abortions** performed by any means including surgical and pharmaceutical methods. (**Note**: Abortions when the life of the mother or baby is in danger is not considered to be an elective abortion.)

2. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs, except as stated under the Other Covered Expenses section of this Plan;

3. **Gene therapies, treatments or enhancements; genetic testing or counseling**, unless used to treat the Sickness or Injury of a Covered Person or used in the treatment of a high risk pregnancy, unless specifically stated otherwise as a Covered Expense. (Note: Certain genetic counseling and testing is payable as shown under the Pregnancy Benefit.)

Medical Limitations and Exclusions – continued

4. The **reversal of voluntary sterilization** procedures;

5. **Midwife labor and delivery services outside of the Hospital** unless the facility is approved by the Plan and meets the definition of Qualified Treatment Facility. (Please refer to the Pregnancy Benefit for information about midwives.)

6. **Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus**;

7. **Childbirth education or preparation courses** (e.g. Lamaze classes); or

8. Treatment of a **sexual dysfunction**. Surgical treatment is not covered. Non-surgical treatment is not covered. Counseling is not covered. Prescription drugs are not covered under the Medical Plan, but they might be covered under the Prescription Drug Card. (The Plan will cover office visits, but not office visits for treatment. It will also cover diagnostic tests, up to the diagnosis of erectile dysfunction.)

ROUTINE AND GENERAL HEALTH

1. **Vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders, **eyeglasses** or the fitting or repair of any eyeglasses. The initial purchase of eyeglasses or contact lenses after a cataract surgery is a Covered Expense. (**Note:** Vision exams are payable as shown on the Schedule of Benefits.)

2. **Hearing aids,** except as shown on the Schedule of Benefits and under the State Mandated Benefits. Hearing exams or tests administered directly or indirectly for fitting a hearing aid or device. The fitting or repair of any hearing aid. (**Note:** Hearing exams and certain hearing aids are payable as shown on the Schedule of Benefits. Certain hearing aids, cochlear implants and related treatment are payable as shown under the Other Covered Expenses and the State Mandated Benefits.)

3. **Prophylactic procedures** to prevent a Sickness that has not occurred yet; or **third party exams**, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment, travel or the purchase of insurance, except as shown under the Wellness Benefit. (**Note**: Immunizations for foreign travel are covered under this Plan. Third party exams for school, sports and camp for Dependent children are covered as shown under the "For Children" section of the Wellness Benefit.)

4. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction, except as stated under the Other Covered Expenses;

5. **Routine foot care**, except when You have a medical diagnosis, such as, but not limited to diabetes, peripheral neuropathies or arteriosclerosis, or as specifically stated under the Other Covered Expenses. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis and nail trimming; or

6. Services or supplies for **physical fitness, wellness, health education, nutritional or dietary supplements or personal hygiene,** except as shown under the Health Club Reimbursement Benefit.)

SERVICES UNDER ANOTHER PLAN

1. Any Injury or Sickness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which You would not be required to pay if You did not have this coverage;

3. Any charges that **would have been paid by Your primary plan** had You complied with all of the prior authorization or pre-certification requirements of that plan;

4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include Medicare or Medicaid);

5. Any service or supply provided in the care of any service related Injury or Sickness (past or present) **if You are in a Hospital or facility owned or operated by the United States Government** or any of its agencies; or

6. Services that Your Dependent child's **school is legally obligated to provide**, whether or not the school actually provides them and whether or not You choose to use those services.

OTHER

1. Charges **in excess of the Usual, Customary and Reasonable charge** for the service or supply;

2. Services **not Medically Necessary** for diagnosis and treatment of an Injury or Sickness;

3. **Custodial care**;

4. Any medical expense incurred **after the date Your coverage under the Plan terminates**, except as specifically described; any medical **expenses incurred while You are not covered** under this Plan;

5. Charges incurred **outside the United States** if You traveled to such location to obtain the service, drug or supply; (If You are traveling on vacation, Covered Expenses due to Sickness or Injury are payable under the Plan.)

6. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony** except if due to domestic violence;

7. Any loss caused or contributed to by:

    a. **war or any act of war**, whether declared or not, or
    b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

8. Treatments aimed at the development or acquisition of a functional ability that has not previously been achieved, except as stated under the Other Covered Expenses;

9. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;

Medical Limitations and Exclusions - continued

10. Services or supplies provided **in connection with or as a result of any service or supply that is not a Covered Expense**, except:

    a. as stated for the treatment of complications resulting from a non-covered service; and

    b. as specifically stated under the Other Covered Expenses section of the Plan (e.g. the Qualifying Clinical Trial benefit).

11. Charges for **legal services**;

12. **Charges for travel,** except as stated under the Ambulance Service Benefit and the Human Organ and Tissue Transplant Benefit; **charges for lodging**, except as stated under the Human Organ and Tissue Transplant Benefit;

13. Replacement of prescription drugs, medications, equipment, orthotics or prosthetics that are **lost, stolen misplaced, missing or are damaged by You**;

14. Charges for **services to educate You or help You adapt to a diagnosis or a chronic physical or mental condition,** except as stated for diabetic self-management education programs;

15. **Services to improve an existing physical or mental state in the absence of a Sickness or Injury,** except as specifically stated otherwise for the treatment of Autism Spectrum Disorders;

16. Services or supplies **for the convenience** of the patient, the Qualified Practitioner, the patient's family or any other person;

17. **Services or treatments that continue after You have reached the expected state of improvement, resolution or stabilization** of a Sickness or Injury**,** except as specifically stated otherwise for the treatment of Autism Spectrum Disorders;

18. **Items that are useful in the absence of a Sickness, Injury or disability.** Including, but not limited to air conditioners, air cleaners and purifiers, humidifiers, whirlpools, dehumidifiers, lift chairs, stair lifts, van lifts, physical fitness items, such as exercise cycles and other similar items for **personal comfort**, **personal hygiene, physical fitness or convenience**; or

19. Additional costs and/or care related to **Wrong Surgeries**. Wrong Surgeries include, but are not limited to, surgery performed on the wrong body part and/or surgery performed on the wrong person.

PRESCRIPTION DRUG CARD

Note: Excludes those who are eligible for Medicare Part D.

A directory or participating pharmacies is available on the Drug Card's web site.

Covered Drugs

Your medical ID card is also used to obtain prescription drugs. This card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." Your pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on Your ID card.

How To Use Your ID Card

Present Your Medical ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If You are without Your Medical ID Card or at a non-participating pharmacy, You may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from Your Employer.

Mail Order Drug Service

If You are using an ongoing prescription drug, You may purchase that drug on a mail order basis. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

The copay for mail order prescriptions is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card web site or from Your Employer. All prescriptions will be mailed directly to Your home.

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SECTION 2 DEFINITIONS

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DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the Plan. Defined words are capitalized throughout the Plan.

Accident
A happening by chance and without intention or design, which is unforeseen, unexpected and unusual at the time it occurs.

Actively at Work
An Employee is Actively at Work if he or she is employed by the Employer on a regular basis and meets the minimum requirements set by the Employer for eligibility under the Plan. An Employee is not considered Actively at Work if he or she has been laid off or is absent from work for reasons other than those which entitle the Employee to leave under family and medical leave laws or a Health Factor, and such layoff or absence from work is for such a period of time that the employee is no longer eligible for the benefits of this Plan pursuant to the rules or policies established by the Employer or the terms of any applicable collective bargaining agreement. Status of employment on a regular basis is determined at the Employer level.

Ambulatory Surgical Center
Any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery and does not provide services or accommodations for patients to stay overnight.

Amendment
A document, duly authorized by the Plan Administrator, that changes any provision of the Plan.

Birthing Center
A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the Birthing Center; 2. Is directed by a Qualified Practitioner specializing in obstetrics and gynecology; 3. Has a Qualified Practitioner or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Business Associate
A Business Associate is a person who provides, other than in the capacity of a Plan Employee, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Plan where the provision of the service involves the disclosure of individually identifiable health information from the Plan or from another Business Associate to the person.

Definitions – continued

Calendar Year
A 12 month period of time that starts on January 1 and ends on December 31.

Chronic Disability
A disability which meets all of the following requirements: 1) It is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) It is likely to continue indefinitely; 3) It results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living and economic self-sufficiency.

Claims Administrator
The person or entity employed by the Plan Administrator to provide administrative services in connection with the operation of the Plan and any other functions including the processing of claims. If no Claims Administrator is employed by the Plan Administrator, Claims Administrator will mean the Plan Administrator.

Complications of Pregnancy
A Sickness or Injury superimposed upon an otherwise normal pregnancy. The Sickness or Injury must have the potential to affect the course or outcome of the pregnancy, or the health of the mother or fetus. Examples of Complications of Pregnancy are preeclampsia, toxemia, gestational diabetes, hyperemesis, gravidarium, ectopic pregnancy, miscarriage and gynecological surgery performed in the six week postpartum period (other than elective sterilization) if the surgery is in connection with or results from the pregnancy. Complications do not include false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness and similar conditions associated with a difficult pregnancy.

Confinement
Being a resident patient in a Hospital for at least 15 consecutive hours per day or being a resident bed patient in an Extended Care Facility or other Qualified Treatment Facility 24 hours a day. Confinement starts with Your admission to a Hospital or other Qualified Treatment Facility and ends with Your discharge from such facility. Generally, successive Confinements are considered one Confinement if they are:

1. Due to the same Injury or Sickness; and

2. Separated by fewer than 30 consecutive days when You are not confined.

If You experience an unexpected recurrence of Your original Sickness or Injury after recovery or You have a new Sickness or Injury, the Plan Administrator may determine that You are entitled to a new period of Confinement.

In all cases, the Plan Administrator determines whether a subsequent confinement is the same period of Confinement or a new period of Confinement.

Covered Dependent
An Employee's eligible Dependent who is properly enrolled in the Plan.

Covered Employee
An Employee who is eligible and properly enrolled in the Plan.
Revised 7/1/17

Definitions - continued

Covered Expense
Expense Incurred by You or Your Covered Dependent for services or supplies provided by a Qualified Practitioner or Qualified Treatment Facility due to an Injury or Sickness if the Expense Incurred is covered by the Plan.

Covered Person
A Covered Employee or Covered Dependent.

Custodial Care
Care to assist in the activities of daily living and care that is not likely to improve Your medical condition.

Dependent
1. A Covered Employee's legal spouse.

2. A covered Employee's domestic partner who is of the same sex and who shares a committed relationship with the Covered Employee which has the following characteristics:

   a. living together at the same residence for at least six months,

   b. having a mutual and exclusive commitment to each other's well-being,

   c. being financially interdependent by sharing common assets and common debts,

   d. neither party being married to anyone nor having another domestic partner,

   e. not being related by blood closer than would bar marriage in the state of their residence, and

   f. both parties being of age for legal marriage.

3. A Covered Employee's married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age. (**Children of Domestic Partners are not eligible for coverage under this Plan.**)

   The limiting age for a Dependent child is the last day of the month in which the child reaches age 26.

   Coverage may be extended (beyond age 26) for a Dependent child if **all** of the following requirements are met:

   a. The Dependent child is a full-time student, regardless of age, and
   b. The Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
   c. The Dependent child was under age 27 when called to federal active duty.

Definition of Dependent - continued

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

1. the date the child's coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

4. A Covered Employee's grandchild, as long as the Employee's Covered Dependent child or legal ward, who is the parent of the grandchild, is not yet 18 years old, or marries, whichever occurs first.

A Covered Dependent child who attains a limiting age while covered under this Plan will remain eligible for benefits if the Plan Administrator determines that all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;

2. The child is incapable of self-sustaining employment because of mental retardation or physical handicap;

3. The child is chiefly dependent on the Covered Employee for support and maintenance; and

4. The child never married.

You must provide satisfactory proof that the above conditions exist within 30 days after the date the limiting age is reached. The Plan Administrator may request such proof annually after two years from the date the limiting age is reached. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

No person may be covered as both an Employee and a Dependent at the same time. If both the Employee and spouse are eligible for coverage under this Plan, only one may enroll for Dependent coverage.

Right to Check Dependent Eligibility
The Plan reserves the right to check the eligibility status of a Dependent at any time during the year. You and Your Dependent have an obligation to notify the Plan when the Dependent's eligibility status changes during the year. Please notify Your Employer of any status changes.

Disability or Disabled
The inability of an Employee to perform adequately the material and substantial duties of his or her regular occupation due to involuntary; medically proven and documented physical or mental impairment(s). The physical or mental impairment(s) causing the Disability must be substantiated in objective, contemporaneous medical records and documentation. For purposes of this definition, the regular occupation is the position that the Covered Employee held on the date that the Plan Administrator determines to be the first day on which the Employee was disabled.

Effective Date
The effective date stated on the front of this Plan.

Definitions – continued

Emergency
Any Injury or Sickness which requires immediate treatment and which if not immediately treated would jeopardize or impair the health of the Covered Person. An Emergency may or may not be life threatening. A condition is considered to be an Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

Employee
You, when You are regularly employed by the Employer.

Employer
Crivitz School District, which employs the Covered Employee.

Enrollment Date
The first day of Your eligibility period or if earlier, Your effective date of coverage under this Plan. If You are a Late Applicant Your Enrollment Date is Your effective date of coverage under this Plan.

Essential Health Benefits
If the Plan covers services that are included under the following categories, as defined under the under the Patient Protection and Affordable Care Act, the Plan may not place annual or Lifetime dollar limits on such services: ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, etc.

Expense Incurred
The amount charged for services and supplies needed to treat the Injury or Sickness. The Expense Incurred date is the date a supply or service is provided.

Extended Care Facility
A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;

2. A Qualified Practitioner's services available at all times;

3. A registered nurse (R.N.) or Qualified Practitioner in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care during convalescence from Sickness or Injury.

Definition of Extended Care Facility – continued

An Extended Care Facility is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Extended Care Facility Confinement
Extended Care Facility Confinement is only a Confinement in an Extended Care Facility which:

1. Begins while You or Your covered Dependent are covered under this Plan;

2. Is necessary for care or treatment of the same Injury or Sickness which caused the prior Hospital Confinement; and

3. Occurs while You or Your covered Dependent are under the regular care of the Qualified Practitioner who certified the required Extended Care Facility Confinement.

Note: A period of "Confinement" is defined as shown in this Plan.

Family
A Covered Employee and the Covered Employee's Covered Dependents.

Family Member
Your lawful spouse, child, parent, grandparent, brother or sister, or any person related in the same way to Your covered Dependent.

Health Factor
The health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including whether an individual is a victim of domestic violence or engages in activities, such as motorcycling, horseback riding, snowmobiling or similar activities, or disability of any Employee or Dependent of any Employee.

Home Health Care
A formal program of care and intermittent treatment that is: Performed in the home; prescribed by a Qualified Practitioner; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or qualified licensed providers under the medical direction of a Qualified Practitioner; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care (e.g. care that is not provided on a continuous, non-interrupted basis).

Home Health Care Agency
A public or private agency or organization which:

1. Specializes in providing medical care and treatment in the home;

Definition of Home Health Care Agency – continued

2. Is primarily engaged in providing skilled nursing services and other therapeutic services;

3. Is duly licensed by all appropriate authorities;

4. Has a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) , and establishes policies to govern the services provided;

5. Has a Qualified Practitioner or registered nurse (R.N.) providing full-time supervision of the services provided;

6. Maintains a complete medical record on each patient;

7. Has a full-time administrator; and

8. Is certified by Medicare.

Home Health Care Plan
A formal, written plan made by the Covered Person's Qualified Practitioner that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care
Palliative and supportive care to terminally ill patients and their families.

Hospice Care Agency
An agency which:
1. has the primary purpose of providing Hospice Care to hospice patients;

2. is licensed and operated according to the laws of the state in which it is located;

3. has obtained any required certificate of need;

4. provides 24-hour-a-day, seven-day-a-week service, supervised by a Qualified Practitioner;

5. has a full-time coordinator;

6. keeps written records of services provided to each patient;

7. has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients;

8. has a licensed social service coordinator;

9. establishes policies for the provision of Hospice Care; assesses the patient's medical and social needs and develops a program to meet those needs;

10. provides an ongoing quality assurance program;

Definition of Hospice Care Agency – continued

11. permits area medical personnel to use its services for their patients; and

12. uses volunteers trained in care and services for non-medical needs.

Hospice Care Program
A written plan of Hospice Care which is established and reviewed by a Qualified Practitioner and the Hospice Care Agency, and describes palliative and supportive care to hospice patients and their Immediate Families.

Hospice Facility
A licensed facility or part of a facility which:
1. principally provides Hospice Care;

2. has 24 hour a day nursing services, provided under the direction of a registered nurse (R.N.);

3. has a full-time administrator;

4. keeps medical records of each patient;

5. has an ongoing quality assurance program; and

6. has a Qualified Practitioner on call at all times.

Hospital
An institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a Qualified Practitioner and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing services;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where it is located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Hospital does **not** include an institution which is principally a rest home, nursing home, convalescent home or a home for the aged, clinics, free-standing surgical center, facilities that provide primarily rehabilitative, education or custodial care, health resorts, spas or sanitariums. Hospital does **not** include a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

Immediate Family
Your spouse, children, parents, grandparents, brothers and sisters and their spouses. (For Hospice Care only, Your Immediate Family is Your parent, spouse and Dependent Children.)

Injury
Physical damage to Your body caused by an external force and due, directly and independently of all other causes, to an Accident.

Inpatient Treatment
Treatment while confined as a registered bed patient in a Hospital or Qualified Treatment Facility.

Late Applicant
An Employee who enrolls for coverage more than 30 days after they are eligible to be covered. A Dependent who is enrolled for coverage more than 30 days (60 days for a newborn child or an adopted child) after they are eligible to be covered.

Lifetime
When used in reference to benefit maximums and limitations, the time You are covered under this Plan, whether or not Your coverage under the Plan is continuous. In no circumstances does Lifetime mean Your life span.

Medically Necessary
Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the Plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

3. Not mainly for Your convenience or that of Your Qualified Practitioner; and

4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Sickness, Injury or symptoms.

The fact that a physician or Qualified Practitioner has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Utilization Management (UM) develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UM and revised from time to time), are available to You by calling UMR, Inc. at the telephone number shown on Your ID card, and to Qualified Practitioners, physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as amended.

Non-Essential Health Benefits
Any Covered Expense that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Outpatient Treatment
Treatment received while not confined in a Hospital or Qualified Treatment Facility, including diagnostic laboratory examinations and psychological testing.

PPO
Preferred Provider Organization. If a provider has contracted with the PPO Network, they are a PPO Provider. PPO providers furnish services at a discounted rate to the Plan. If a provider has not contracted with the PPO Network, they are a Non-PPO provider.

Pediatric Services
Services provided to a Covered Person under 19 years of age.

Plan
The plan of medical expense benefits described in this document and including any schedules, attachments and Amendments to this document. Prior, current and successive plans will be considered one plan and not separate and distinct plans.

Plan Administrator or Trust
WCA Group Health Trust.

Plan Sponsor
The Plan Sponsor of the Plan is WCA Group Health Trust.

Plan Year
A 12 month period of time that starts on July 1 and ends on June 30.

Definitions – continued

Post-Service Claim
Any claim that is not a Pre-Service Claim.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the Plan for the medical care.

Prior Authorization
The process of determining benefit coverage prior to service being rendered to a Covered Person. A determination is made based on Medical Necessity (Medically Necessary) criteria for services, tests or procedures that are appropriate and cost-effective for the Covered Person. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Protected Health Information
Protected Health Information means individually identifiable health information that is: transmitted or maintained in any form or medium; is created or received by a health care provider, the Plan an employee or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual.

Prudent Layperson
A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified Practitioner
A provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan. A Qualified Practitioner's services are not covered if the practitioner resides in Your home or is a Family Member.

Qualified Treatment Facility
A duly licensed facility, institution or clinic, operating within the scope of its license.

Sickness
1. A disease or disturbance in function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of Your body;

2. Muscle tiredness or soreness resulting from overexertion in a physical activity; or

3. Pregnancy.

Transitional Treatment
Treatment for nervous or mental disorders, alcoholism or other drug abuse that is provided in a less restrictive manner than Inpatient Treatment, but in a more intensive manner than Outpatient Treatment.

Urgent Care
Any care that in the opinion of Your Qualified Practitioner is an urgent care situation. Any care that the use of non-urgent care time frames would put Your life, health or ability to regain maximum function at risk.

Usual, Customary and Reasonable (UCR)
For Non-PPO Providers, the lesser of the fee most often charged by the provider or the maximum allowable fee as determined by the Plan. The maximum allowable fee is set by comparing the service to a national database of fees. The database is adjusted to the locality where the service was performed.

1. If more than one surgery is performed during an operative session, the Covered Expense will be limited. The Usual, Customary and Reasonable (UC&R) fee for the primary surgical procedure will be payable. 50% of the UC&R fee for the secondary procedure will be payable. 50% of the UC&R fee for the third and following procedures will be payable.

2. The UC&R fee for an assistant surgeon or physician's assistant is based on the UC&R fee for the primary surgeon.

In the case of a PPO Provider, it will mean the negotiated PPO discount rate for the service or procedure.

You and Your
You as the Covered Employee and any of Your Covered Dependents, unless otherwise provided.

SECTION 3 ELIGIBILITY

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to Employees hired on or after the effective date of this Plan. The Dependent Coverage section applies to Dependents that are added on or after the effective date of this Plan.

Employees who were covered under any plan that this Plan replaces will be covered on the effective date of this Plan. Coverage will include Dependents of such an Employee. You must have met the eligibility requirements of the Plan.

RETIRED EMPLOYEES

If You are retired on the date this Plan takes effect, You are eligible for coverage under this Plan on the effective date of the Plan, if all of the following apply:

1. The Active Employees in the eligible class from which You retired are covered by this Plan;

2. On the day before this Plan takes effect, You were covered under the group health policy that this Plan replaces; and

3. Your enrollment form is received within 30 days of the date this Plan takes effect.

Refer to the Retiree Coverage section of this Plan for more information about Retiree coverage.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the Plan if You are an Employee who meets the eligibility requirements of the Employer.

You are eligible to be covered on the first day of the month after Your employment with the Employer begins. This is Your eligibility date.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms furnished and accepted by the Plan Administrator. Each Employee's effective date of coverage is determined as follows:

1. If Your completed enrollment forms are received by the Plan Administrator within 30 days of Your eligibility date, Your coverage is effective on Your eligibility date.

2. If Your completed enrollment forms are received by the Plan Administrator **more than** 30 days after Your eligibility date, this is considered **late enrollment**. You will not be eligible to enroll for coverage until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Employee coverage will begin at 12:01 AM, Standard Time, on Your effective date. You must actually begin performing work with the Employer before coverage will be effective under the Plan.

Please refer to the **Special Enrollment Rights** section of this Plan for additional enrollment rights and events.

DEPENDENT ELIGIBILITY

Each Dependent is eligible for coverage on the later of:

1. The date the Employee is eligible for coverage, if the Employee has Dependents on that date;

2. The date of the Covered Employee's marriage for any Dependents acquired on that date;

3. The date of birth of the Covered Person's natural born child;

4. The date a valid court order is issued which, by federal law or Plan provision, requires the Plan to provide coverage;

5. For an adopted child: An adopted child is eligible for coverage on the date that a court makes a final order granting adoption or on the date that the child is legally placed with the Covered Employee for adoption, whichever is earlier. Coverage for the adopted child will begin on the date of eligibility if the required enrollment form for the adopted child is received by the Plan Administrator within 60 days of that date; or

6. For a legal ward: A legal ward is eligible for coverage on the date established by the court order as the date which You begin guardianship. Coverage for the legal ward will begin on the date he or she became eligible if:

    a. You have family coverage in effect; and

    b. The Plan Administrator receives the required enrollment form to add the legal ward within 30 days after he or she first became eligible.

Dependents of an Employee may be covered only if the Employee is also covered.

If both the Employee and a Dependent are eligible for Employee coverage under this Plan, each Covered Expense is payable only once and each Covered Person is covered only once.

DEPENDENT EFFECTIVE DATE OF COVERAGE

Each Dependent's effective date of coverage is determined as follows:

1. If a Dependent's completed enrollment forms are received by the Plan Administrator within 30 days of the Dependent's eligibility date, that Dependent is covered on his or her eligibility date.

2. An eligible newborn of a Covered Person is covered for 60 continuous days from the moment of birth. If the newborn's enrollment forms are received by the Plan Administrator within 60 days of the date of birth, then the newborn will be a Covered Dependent effective the moment of birth.

3. If the newborn's enrollment forms are received by the Plan Administrator more than 60 days and within one year after the date of birth and the Covered Employee makes all past due premium payments with interest at the rate of 5 ½% per year, than the newborn will be a Covered Dependent effective the moment of birth.

4. If You marry after Your coverage is effective, You should apply for Family Coverage within 30 days of Your marriage. If You do, Your Family Coverage becomes effective on the date of the marriage.

Dependent Effective Date of Coverage – continued

5. If a Dependent's completed enrollment forms are received by the Plan Administrator more than 30 days after the Dependent's eligibility date, this is considered **late enrollment**. Such Dependent will not be eligible to enroll for coverage until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Dependent coverage will begin at 12:01 AM, Standard Time, on the Dependent's effective date of coverage under the Plan.

Please refer to the **Special Enrollment Rights** section of this Plan for additional enrollment rights and events.

RETIREE COVERAGE

If You were covered under this Plan on the date of Your retirement, You may be eligible for Retiree Coverage under this Plan at the time of Your retirement. Retiree Coverage will apply according to the terms defined by Your Employer.

If You elect Retiree Coverage, the Retiree Coverage will run concurrent with COBRA Continuation. If an alternate coverage is offered (e.g. Retiree Coverage), COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision (including retiree coverage) which runs concurrent with COBRA coverage.

The Special Enrollment Rights provision stated in this Plan does not apply to Retiree Coverage.

NOTE: If You are Medicare eligible, claims must be submitted to Medicare first. After Medicare has processed Your claim, the claim and the Medicare EOB should be submitted to this Plan.

ANNUAL OPEN ENROLLMENT PERIOD

Each year, Your Employer will provide an enrollment period. Once You have made elections for the year, Your choices cannot be changed until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Completed enrollment forms must be received by the Plan Administrator before the end of the Annual Open Enrollment Period. If Your completed enrollment form is not received by that time, You will not be able to enroll in the Plan or make changes until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Your Employer will notify You when the Annual Open Enrollment Period is each year.

Note: The Annual Open Enrollment does not apply to Retiree Coverage.

Changes In Status

If You have a change in status, as defined by the IRS, You have 30 days from the date of that change to make new elections under this Plan. Any changes in Your elections must be consistent with Your change in status or they will not be allowed. Change in status means only a change as stated below.

1. **Legal Marital Status**. Your marriage, divorce, legal separation, annulment or the death of Your legal spouse;

Annual Open Enrollment Period – continued

2. **Number of Dependents**. An increase or decrease in the number of Dependents You have due to birth, adoption, placement for adoption or the death of a dependent;

3. **Employment Status**. Any of the following events that change the employment status of You or Your Dependent, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;

4. **Dependent Status**. Your Dependent satisfies or ceases to satisfy eligibility requirements for coverage;

5. **Residence**. Any change in residence for You or Your Dependent;

6. **FMLA Leave Status**. At the time a leave under the FMLA begins the Employee may change elections to the extent allowed under the federal *Family and Medical Leave Act;*

7. **COBRA Continuation**. You or Your Dependent become eligible for and elect continuation coverage under the Employer's group health plan as provided by *COBRA* or a similar State law;

8. **Judgment, Decree or Court Order**. An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires *you* or another individual to provide health coverage for Your Dependent child;

9. **Entitlement to Medicare or Medicaid**. A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for You or Your Dependent;

10. **HIPAA Special Enrollment Rights**. An event which qualifies as a special enrollment right under the *Health Insurance Portability and Accountability Act*;

11. **Significant Cost Increase**. Election changes are limited to increasing Your election to cover the cost increase or changing the election to provide for a similar benefit offered by the employer;

12. **Significant Curtailment of Coverage**. An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;

13. **Addition or Elimination of a Benefit Option**. Election changes are limited to electing the new benefit option in the case of an added benefit option or electing a similar benefit in the case of the elimination of a benefit option;

14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of Your spouse's, ex-spouse's or other Dependent's employer. To qualify as a change in status under this plan the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If You have questions regarding whether an event qualifies as a change in status, the Claims Administrator will answer them.

SPECIAL ENROLLMENT RIGHTS

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Applicant provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

Loss of Other Coverage

If You declined coverage under this Plan in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to Your exhaustion of the maximum COBRA period;

2. Due to Your involuntary loss of eligibility, for any reason; or

3. Employer contributions towards the cost of the other coverage,

Then a special enrollment event has occurred. At that time, an Employee or Dependent may be enroll in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependent may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;

2. When a Dependent has a loss of coverage, that Dependent, the Employee and other Dependents may enroll. The Employee and the Dependents do not have to have had a loss of coverage at that time to enroll.

You must enroll in this Plan within 30 days of the date of a loss of other coverage to be a timely entrant to the Plan. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this Plan will not be effective until such proof is provided. Coverage under this Plan will be effective on the day coverage under the other group plan ends.

If You apply more than 30 days after the date the other coverage ends, You will be a Late Applicant under this Plan.

Retirement

If You are retiring from Active Work under this Plan, a special enrollment event will occur on the date of Your retirement, provided You are eligible for Retiree Coverage as stated in this Plan.

You must enroll for Retiree Coverage within 30 days of the date of Your retirement to be a timely enrollee for Retiree Coverage. Coverage under the Plan will be effective on the day of Your retirement.

If You apply for Retiree Coverage more than 30 days after the date of Your retirement, You will not be eligible to enroll for Retiree Coverage at a later date.

Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage may also be enrolled at this time, as well as any other eligible Dependents that were not previously covered under the Plan.

You must enroll in this Plan within 30 days of the date of marriage to be a timely entrant to the Plan. Coverage under the Plan will be effective on the day of Your marriage.

Special Enrollment Rights - continued

If You apply more than 30 days after the date of Your marriage, it will be considered Late Enrollment under this Plan.

Birth, Adoption or Placement for Adoption

If You experience the birth of a Dependent child, or the adoption or placement for adoption of a Dependent child, a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse, newborn or adopted child may also be enrolled at this time, as well as any other Dependents that were not covered under the Plan may also be enrolled at this time.

You must enroll in this Plan within 30 days (60 days for a newborn or adopted child) of the date of birth, adoption or placement to be a timely entrant to the Plan. Coverage under the Plan will be effective on the date of such an event.

If You apply more than 30 days (60 days for a newborn or adopted child) after the date of such an event, it will be considered Late Enrollment under this Plan.

Limitations

This Special Enrollment Rights provision does <u>not</u> apply to You or Your Dependents if:

1. You are on an unpaid Leave of Absence (unless You have continued Your coverage on this Plan under Your legal rights to coverage continuation (e.g. COBRA) or You are on leave under the Family and Medical Leave Act);

2. You are covered under the Retiree Coverage provision of this Plan (if offered); or

3. You are covered under the Survivorship Continuation provision of this Plan, if applicable.

MEDICAID/STATE CHILD HEALTH PLAN

If You and/or Your Dependents were covered under a Medicaid plan or State child health plan and Your coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this Plan within 60 days after the date of termination of such coverage. Coverage under this Plan will be effective on the date the other coverage ends.

If You apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, You will be considered a Late Applicant under this Plan.

Premium Assistance

Current Employees and their eligible Dependents may be eligible for a special enrollment event if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or State child health plan, for premium assistance with respect to coverage under this Plan. You must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance. If You apply for coverage more than 60 days after this date, You will be considered a late Applicant under the Plan.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all Employees and Dependents. Any change in coverage will be effective on the date of change for all Employees and Dependents.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

If You continue to pay the required Plan contributions, Your coverage will remain in force during an approved, medical leave of absence for no longer than the period of time that is determined by the Board. Such leave of absence must be a non-military, non-FMLA leave of absence.

Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The Plan must remain in effect for this provision to apply.

At the end of this period, COBRA continuation will be offered to any eligible person.

SURVIVORSHIP CONTINUATION

If the Employee dies prior to age 55

If You have Dependent coverage in force on the day that You die, Your covered Dependents have the continuation rights required by state and federal law (i.e. COBRA Continuation will be offered to any eligible Dependents). When that period of Continuation ends, such Dependents may choose coverage under the Employer's Conversion Policy.

If, during the Continuation period, Your surviving spouse obtains coverage for a new spouse or children who qualify as Dependents under this Plan, coverage for the new Dependents will be effective only for the spouse's remaining period of Continuation. The new Dependents have no rights to continue coverage after the surviving spouse ceases to be eligible for coverage or they no longer qualify as Dependents under this Plan.

If a Dependent child is born to the surviving spouse during the Continuation period, that child may be added to the coverage. The child will have all of the rights that any other child would have under Continuation. If a child is adopted by or placed for adoption with the surviving spouse during the Continuation period, that child may be added to the coverage. The child will have all of the rights that any other child would have under Continuation, independent of the surviving spouse.

If the Employee dies while age 55 or older

If You have Dependent coverage in force on the date that You die, coverage under this Plan will continue for Your covered, eligible Dependents. The surviving Dependents must pay the required Plan contribution amount. Survivorship Continuation will end on the earliest of:

1. The end of the period for which any required Plan contribution was due and not paid;
2. The date the Plan no longer covers the Active Employees within the eligible class of eligible Employees to which You belonged at the time of Your death;
3. The date the Dependent no longer meets this Plan's definition of a Dependent;
4. For a Dependent child, the date the surviving spouse ends family coverage; or
5. The date You (the Dependent) die.

Your Dependents will be eligible for the same Plan and benefits that are in effect for the active Employees that are within the eligible class of Employees that You belonged to at the time of Your death.

Survivorship Continuation - continued

If, during this continuation period, Your surviving spouse obtains coverage for a new spouse or children who qualify as Dependents under this Plan, coverage for such new Dependents will be effective only for Your spouse's remaining period of Continuation that is required by state or federal law (e.g. COBRA Continuation). Such new Dependents have no rights to continue coverage under this Plan after Your surviving spouse ceases to be eligible for coverage or they no longer meet this Plan's definition of a Dependent.

This continuation period will run concurrently with any continuation of coverage required by state or federal law (e.g. COBRA). Such Continuation will **not** be offered at the end this period. If an alternate coverage is offered (i.e. this Survivorship provision) the Continuation period will be reduced to the extent such coverage satisfies the requirements of Continuation. Alternate coverage includes continuation by: state law; USERRA; or any other Plan provision.

Rights of Surviving Dependent Children

If Your surviving covered Dependent child chooses single coverage under this Plan at the time of Your death, continuation coverage rights for such child will be limited to those required by state or federal law (e.g. COBRA Continuation). When that period of Continuation ends, such child may choose coverage under the Employer's Conversion Policy.

REHIRED EMPLOYEES AND REINSTATEMENT OF COVERAGE

If Your coverage under this Plan ends due to termination of employment, leave of absence, reduction of hours or layoff and You qualify for eligibility under this Plan again (e.g. You are rehired or are considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage under this Plan will be reinstated on the first day of the month after You are rehired or are considered to be rehired for purposes of the Affordable Care Act. If Your coverage ends due to termination of employment, leave of absence, reduction of hours or layoff and You do not qualify for eligibility under this Plan again (e.g. You are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;

2. For any benefit, the date removal of the benefit from the Plan by Amendment is effective;

3. The end of the period for which any required Employee or Employer contribution was due and not paid;

4. The date You enter the full-time military, naval or air service of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

5. The last day of the month in which You cease to be eligible according to the eligibility requirements of the Employer;

6. For all Employees, the last day of the month in which Your termination of employment with the Employer occurs or, if earlier, the last day of the month in which You are no longer Actively at Work as defined in this Plan;

7. For Employees, the last day of the month in which You retire, unless You are eligible for and elect Retiree Coverage;

8. For a Dependent, the date the Employee's coverage terminates;

9. For a Dependent, the date You enter the military forces of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

10. For a Dependent, the last day of the month in which such Dependent no longer meets this Plan's definition of a Dependent. (Refer to the definition of Dependent in Section 2 of this Plan.)

11. For an Employee's spouse, the date of entry of a judgement of divorce or annulment of the marriage;

12. The date You request termination of coverage to be effective for Yourself and/or Your Dependents; or

13. The last day of the month in which You die. (If an Employee dies while covered under this Plan, that Employee's covered Dependent Spouse and covered Dependent children may be allowed to stay on this Plan until the last day of the month in which the Employee dies; or continue coverage as stated under the Survivorship Continuation provision of this Plan, if applicable).

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect;

2. It is attributable to non-payment of premiums or contributions; or

3. It is initiated by You or Your personal representative.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

The Plan cannot terminate Your coverage due to age or Medicare status. An active Employee that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this Plan, in which case Medicare benefits would be secondary to this Plan, or

2. End coverage under this Plan, in which case Medicare would be the only coverage available to You.

An active Employee's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.

Contact Your Employer for further information.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to Employers with 50 or more Employees. It requires that coverage under this Plan be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the Employee as it would have been had FMLA leave not been taken.

If this Plan is established while You are on FMLA, Your coverage will be effective on the same date it would have been had You not taken leave. If the Plan is amended while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken leave.

EMPLOYEE ELIGIBILITY

An Employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The Employee has been employed with the Employer for a total of at least 12 months;

2. The Employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and

3. The Employee is employed at a worksite that employs at least 50 Employees.

TYPES OF LEAVE

Coverage under this Plan can be continued during a period of FMLA leave. The Employee must continue to pay the Employee portion of the Plan contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the Employer, for:

1. The birth of the Employee's child;

2. The placement of a child with the Employee for adoption. The placement of a child with the Employee for foster care;

3. The Employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;

4. The Employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or

5. Any qualifying necessity that results from the Employee's spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the Employer, to care for a member of the armed forces that is the Employee's spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

Maximum Leave Period

The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the Employee and the Employee's spouse are both employed by the Employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;

2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or

3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period

If the Employee decides not to return to work, coverage under the Plan may end at that time.

If the Plan contribution is not paid within 30 days of its due date, coverage under the Plan may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an Employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions

The Employer has the right to recover the portion of Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave. If the Employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work. Reinstatement will apply whether coverage under the Plan was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived.

DEFINITIONS

For this provision only, the following terms are defined as shown below:

Serious Health Condition is any Sickness, Injury, impairment or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;

FMLA - continued

2. Continuing treatment by a Qualified Practitioner, including any period of incapacity:

    a. for more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or a Qualified Practitioner is consulted at least once and a continuing treatment program is provided;
    b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
    c. due to a chronic condition (i.e. a condition which requires periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
    d. which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective;
    e. to receive multiple treatments from a Qualified Practitioner for restorative surgery due to Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

    Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is Your lawful husband or wife.

Son or Daughter is Your natural blood related child, adopted child, step-child, foster child, a child placed in Your legal custody or a child for which You are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or

2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is Your natural blood related parent or someone who has acted as Your parent in place of Your natural blood related parent.

NOTE: To the extent that State or local law requires an Employer to provide greater leave rights than those stated above, this Plan will provide that greater right. For complete information regarding Your rights under the FMLA, contact Your Employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that the Employer provide a cumulative total of five years, and in certain instances more than five years, of military leave during an Employee's employment with the Employer.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that the Employer continue to provide coverage under this Plan, during a military leave that is covered by the Act, for You and Your Dependents. Coverage provided must be identical to coverage provided under the Employer's Plan to similarly situated, active Employees and Dependents. This means that if the coverage for similarly situated, active Employees and Dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the Employee contribution required for active Employees;

2. For military leaves of 31 days or more, up to 102% of the full contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages. Short and long term disability and life benefits are not subject to this provision.

For an Employer subject to COBRA, continued coverage provided under this Act will reduce any continuation provided under COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Employer following completion of Your military leave. Employees must return to employment within:

    a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b. 14 days of completing military service, for leaves of 31 to 180 days,
    c. 90 days of completing military service, for leaves of more than 180 days; or

2. 24 months from the date Your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day of completing Your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

2. 14 days of completing Your military service, for leaves of 31 to 180 days;

3. 90 days of completing Your military service, for leaves of more than 180 days.

USERRA - continued

If, due to a Sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived as if You had been continually covered under the Plan from Your original effective date.

This waiver of limitations does not provide coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veterans Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to Employers that have 20 or more employees. The law requires these Employers to offer covered individuals continuation coverage (COBRA) under the Plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The Employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active Employees under the Plan. This means that when coverage is changed for similar active Employees it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work; or

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part.

Spouse Rights to COBRA

The spouse of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, divorce, or legal separation; or

5. The Employee becoming entitled to Medicare.

Dependent Child Rights to COBRA

The Dependent child of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The Employee becoming entitled to Medicare; or

COBRA – continued

6. The child ceasing to be considered a Dependent child as defined in this Plan.

Electing COBRA

Each person covered by this Plan has an independent right to elect COBRA for himself or herself. A Covered Employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the Employee's Dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the Employee during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, You have a right to elect COBRA. You also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the Employer files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, You must inform the Plan Administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. You must also inform the Plan Administrator within 60 days of a child no longer meeting the Plan's definition of Dependent. Notice must be provided within the 60-calendar day period that begins on the latest of:

1. The date of the qualifying event; or
2. The date on which there is a Loss of Coverage (or would be a loss of coverage) due to the original qualifying event; or
3. The date on which the qualified beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Employer must notify the Plan Administrator of: the Employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The Employer must also notify the Plan Administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the Plan Administrator will notify You that You have the right to elect COBRA. If the Employer and Plan Administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law You must elect COBRA within 60 days from the later of: the date You would lose coverage or cost would increase due to the qualifying event; or the date notice of Your right to COBRA and the election form are sent.

The Plan Administrator must provide You with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If You elect COBRA within the 60 day period, COBRA will be effective on the date that You would lose coverage. If You do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the Plan will terminate.

COBRA - continued

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The Plan may add a 2% administration charge to that cost. The Plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

The cost of continuation coverage is subject to change at least once per year. The timing of the one-year period is set by the Plan Administrator.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the Employer maintain COBRA for up to:

1. 18 months, if due to the Employee's termination of employment. Termination must be for reasons other than gross misconduct on the Employee's part;

2. 18 months, if due to the Employee's reduction in work hours;

3. 36 months, if due to the death of the Employee;

4. 36 months, if due to the end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. 36 months, if due to the Employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the Employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to Your ceasing to be a Dependent child as defined in the Plan; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered Dependent may elect COBRA for an additional 36 months from that date.

If You or a Dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if You or a Dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the Plan Administrator within 60 days of the later of:

1. The date of the Social Security Act disability determination;
2. The date that the qualifying event occurs;
3. The date the qualified beneficiary loses (or would lose) coverage due to the original qualifying event or the date that Plan coverage was lost due to the original qualifying event; or
4. The date on which the qualified beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

COBRA – continued

This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, You will not be eligible for the extended period. If it is determined that You are no longer disabled, You must notify the Plan Administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the Employee's death; the Employee's divorce; a child no longer meeting the definition of Dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the Plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The Employer no longer provides a group benefit plan to any of its Employees;

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;

3. You obtain another group plan after the date you elect COBRA;

4. You become entitled to Medicare after the date you elect COBRA;

5. There has been a final determination that You are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Procedures for Providing Notice to the Plan

In order to maintain Your rights under COBRA, You are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if You provide written notice to the Plan Administrator that includes:

1. The Employee's name and participant number;

2. The name of the individual(s) to whom the notice applies;

3. The reason for which notice is being provided; and

COBRA – continued

4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The Plan Administrator will answer any questions You may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to Your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect Your rights under COBRA, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status; address; or other insurance coverage. When providing any notice to the Plan, a copy should be maintained for Your own records.

SPECIAL NOTICE

(Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA qualifying event, a qualified beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the HIPAA Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the qualified beneficiary will lose his or her Special Enrollment Rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the qualified beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or exchange. After COBRA continuation coverage is exhausted, the qualified beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange in accordance with his or her HIPAA special enrollment rights.

INDIVIDUAL MEDICAL CONVERSION PRIVILEGE

An individual conversion plan is available from the Trust. The Plan Administrator will, during the 180-day period before the applicable end of continuation coverage, offer a Covered Person who is covered until the end of the maximum period of continuation coverage the option of enrollment under a Conversion health plan.

If an individual Conversion health plan is not available from the Trust, You may continue group coverage until:

1. The individual on continuation coverage establishes residence outside the State that the Employer is located in;

2. The individual on continuation coverage fails to make a timely payment of a required premium amount;

3. For an individual on continuation coverage who is eligible for continued coverage as the former spouse of a Covered Person and who would otherwise terminate coverage because of divorce or annulment, the Covered Person through whom the former spouse originally obtained coverage is no longer eligible for coverage by the Plan; or

4. The individual on continuation coverage becomes eligible for similar coverage under another plan.

Benefits provided under Conversion may differ from those of this Plan.

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SECTION 4 GENERAL PLAN INFORMATION

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COORDINATION OF BENEFITS

Benefits Subject to This Provision

Benefits described in this Plan are coordinated with benefits provided by other plans which also cover You. This is to prevent the problem of overinsurance and a resulting increase in the cost of coverage. This coordination of benefits provision applies whether or not You file a claim under any other plan You may be covered under.

Effect on Benefits

Benefits will be reduced under certain circumstances when You are covered both under this Plan, as described, and any other plan, as defined below, which provides similar benefits. Total reimbursement from all plans will not exceed 100% of the total Covered Expenses under this Plan.

Definitions

For this Coordination of Benefits provision only, a plan is any coverage which covers medical, dental or vision expenses and provides benefits or services by: :

1. Group or franchise insurance coverage, whether insured or self-funded;

2. Hospital or medical service organizations on a group basis and other group pre-payment plans;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage sponsored or provided by or through an educational institution;

5. Any governmental program or a program mandated by state statute;

6. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group type contracts not available to the general public obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket or in something else.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Covered Expenses. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the Customary, Usual and Reasonable value of each service provided will be deemed to be both a Covered Expense and a benefit paid. No plan will pay more than it would have paid without this provision.

Coordination of Benefits - continued

Order of Benefit Determination

A plan will be considered the primary plan and pay benefits first if.

1. The plan has no coordination of benefits provision.

2. The plan covers the person as an Employee.

3. When a Dependent child is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering a parent for the longest period of time will pay benefits first. If a plan other than this Plan does not use the birthday rule and uses the gender rule instead, then the gender rule will be followed.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:

   a. the plan of a parent who has primary physical placement will be primary,
   b. the plan of a step-parent that has primary physical placement will pay benefits next,
   c. the plan of a parent who does not have primary physical placement will pay benefits next, and
   d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

   If one parent has been assigned financial responsibility for the medical expenses of the child, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:

   a. the plan of a parent who has primary physical placement will pay the benefits first,
   b. the plan of a parent who does not have primary physical placement will pay benefits next,
   c. the plan of a grandparent whose child has primary physical placement will pay benefits next,
   d. the plan of a grandparent whose child does not have primary physical placement will pay benefits next.

   Subject to the order of benefit determination stated above, if both grandparents in a household are providing coverage for a grandchild, the plan of the grandparent whose birthday (month and day) occurs first in the Calendar Year will pay before the plan of the other grandparent. If both grandparents in a household have the same birthday, the plan covering a grandparent for the longest period of time will pay benefits first.

   If the primary plan is not established by the above rules, the plan that has covered the grandparent or parent for the longest period will be primary.

7. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits <u>after</u> the plan covering such persons as an active employee or the dependent of an active employee. **There are two exceptions to this**: a) If a plan other than this Plan does not include a provision similar to this one and, if as a result, the plans do not agree on the order of benefits, this rule will be ignored, and b) If a Dependent is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule.

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Coordination of Benefits - continued

8. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this Plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

If a service is covered under a medical plan and a dental plan, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare

In all cases, coordination of benefits with Medicare will conform to Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan are subject to the allowable limiting charges, as set by Medicare, and will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal Statutes and Regulations.

When Medicare is the primary payer:

1. This Plan will pay 100% after Medicare, less any Medicare payments or discounts;

2. The medical deductible, copays and coinsurance will not apply except for Rx drugs (if applicable) or unless otherwise indicated;

3. All services covered for active Employees will be covered for Medicare-primary individuals, even if Medicare does not cover the service;

4. All services that Medicare covers will be covered for Medicare-primary individuals, even if the service is not covered for an active Employee under this Plan; and

5. When Medicare allows a service, the Plan will pay up to the 100% coordination of benefits (COB) amount for that service, after Medicare has paid its benefit for such service. Once Medicare has exhausted its benefit for a service, the Plan will no longer pay benefits on that service. If there is a service that is completely excluded from Medicare, the active Plan will be reviewed to see if there is a benefit for that service. If the service is a Covered Expense under the active plan, the benefit for such service will be paid at 100% (e.g. chiropractic services or vision exams).

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this Plan, You agree to all of the following conditions. The payment of any claims by the Plan is an advancement of Plan assets. The Plan has first priority to receive repayment of those Plan assets out of any amount You recover. The Plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before You receive payment from that party. The Plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The Plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not you are made whole.

The Plan will not pay attorney fees without the express written consent of the Plan Administrator. The Plan will not pay any costs associated with any claim or lawsuit without the express written consent of the Plan Administrator.

If You are deceased, the rights and provisions of this section will apply equally to Your estate. If You are legally incapacitated the rights and provisions of this section will apply equally to Your legal guardian.

In consideration of the coverage provided by this Plan, when You file a claim You agree to all of the following conditions. You will sign any documents that the Plan considers necessary to enforce its recovery rights. You *will* do whatever is necessary to enable the Plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the Plan any rights You have for expenses the Plan paid on Your behalf. You will hold any settlement funds in trust, either in a separate bank account in Your name or in Your attorney's trust account, until all Plan assets are fully repaid or the Plan agrees to disbursement of the funds in writing, if You receive payment from any liable or responsible party and the Plan alleges that some or all of those funds are due and owed to the Plan. You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the Plan. It also includes any medical, dental or loss of time expense that may be payable by the Plan in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; You or Your Covered Dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the Plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of Your benefits under this Plan.

Right of Subrogation

If, after payments have been made under this Plan, You have a right to recover damages from a responsible or liable party, the Plan shall be subrogated to that right to recover. The Plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the Plan.

Right of Reimbursement

If benefits are paid under this Plan and You recover from a responsible or liable party by settlement, judgment or otherwise, the Plan has a right to recover from You. Recovery will be in an amount equal to the amount of Plan assets paid on Your behalf. The Plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of Plan assets that are paid or payable for any health care expenses under the Plan.

Excess Coverage Provision

Benefits are not payable for an Injury or Sickness if there is any responsible or liable party providing coverage for health care expenses You incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the Plan may make payments on Your behalf for Covered Expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the Plan and will be considered an advancement of Plan assets to You.

This Plan does not provide benefits or may reduce benefits for any present or future Covered Expenses that You have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the Plan.

Workers' Compensation

This Plan excludes coverage for any Injury or Sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the Plan and You receive Workers' Compensation for the same incident, the Plan has the right to recover. That right is described in this section. The Plan reserves its right to exercise its recovery rights against You even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the Injury or Sickness was sustained in the course of or resulted from Your employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by You or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.

You must notify the Plan Administrator of any Workers' Compensation claim You make. You agree to reimburse the Plan as described above.

GENERAL PROVISIONS

The following provisions are to protect Your legal rights and the legal rights of the Plan.

ALTERNATE RECIPIENTS

If a court order requires a Covered Person to provide health care coverage for a Dependent child, coverage must be provided to the child. Coverage may not be subject to Plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of Dependents are also waived for that child. If a Covered Person does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an Employee under the Plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the Plan. They must be provided with a copy of the Plan's Summary Plan Description (SPD). Any payments made by the Plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

A court order will not entitle the child to any benefits or coverage not already offered by the Plan.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan's benefits may be amended by the Employer at any time. The Plan may be terminated by the Employer at any time. Any changes to the Plan will be communicated immediately by the Employer to the persons covered under the Plan.

If the Plan is terminated, the rights of the Covered Persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. Plan assets will be allocated to the exclusive benefit of the Covered Persons. Any taxes and expenses of the Plan may be paid from the Plan assets.

ASSIGNMENT

Any assignment will only be applied to the extent that the provider of services will refund any erroneous payments. The Plan Administrator does not guarantee the legal validity or effect of any assignment.

CLERICAL ERROR

A clerical error by Your Employer, the Plan Administrator or the Claims Administrator will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

CONFORMITY WITH APPLICABLE LAWS

If any provision of this Plan is contrary to any applicable law, that provision is amended to conform to such law and the rest of the Plan remains in effect.

CONTRIBUTIONS TO THE PLAN

The Plan is funded by contributions from the Employer and Covered Employees.

The Employer determines the amount of the Employee contribution, if any, and reserves the right to adjust or modify such contributions. All Employee contributions are on a non-discriminatory basis.

COOPERATION

You must cooperate with the Plan Administrator, Claims Administrator, and or any person designated by the Plan Administrator in connection with this Plan.

FAILURE TO ENFORCE PLAN PROVISIONS

No failure to enforce any provision of the Plan will affect the right, thereafter, to enforce such provision or affect the right to enforce any other provisions of the Plan.

FREE CHOICE OF PROVIDER

The Covered Person has a free choice of any legally licensed provider. The Plan will not interfere with the provider/patient relationship.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

This Plan is not financed or administered by an insurance company and benefits are not guaranteed by a contract of insurance.

If You have any questions about Your rights under the Health Insurance Portability and Accountability Act of 1996, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S, Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 2000 Constitution Avenue, N.W., Washington D.C. 20210.

LEGAL ACTIONS

You cannot bring an action to compel payment under the Plan until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the Plan has denied full payment of Your claim, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

PAYMENT OF CLAIMS

Any payment made in good faith will fully discharge the Plan to the extent of such payment. If benefit payments have been made under any other plan which should have been made under this Plan, the Plan Administrator may reimburse such plan. Any payments made in good faith will fully discharge the Plan's obligations to You to the extent of such payment.

Benefits will be paid directly to the provider of services, unless You direct otherwise in writing at the time proof of loss is filed.

Payment of Claims Provision - continued

Benefits payable on behalf of You or Your Covered Dependent, upon death, will be paid at the Plan Administrator's option to: Your estate; Your spouse; Your Dependent children; Your parents; or Your brothers and sisters.

PHYSICAL EXAMINATION

The Plan Administrator, at its own expense, has the right to have You examined as often as it deems reasonably necessary while a claim is pending.

PRIVACY OF PROTECTED HEALTH INFORMATION

1. **Plan Sponsor's Certification of Compliance**

   Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. **Purpose of Disclosure to Plan Sponsor**

   a. The Plan and any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of Wisconsin law and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Such disclosure will include disclosure for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in the Plan's Notice of Privacy Practices. Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.

   b. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.

   c. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

3. **Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information**

   a. The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.

   b. The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' Protected Health Information.

   c. The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

d. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

e. The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524 and any applicable Wisconsin law.

f. The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526 and any applicable Wisconsin law.

g. The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528 and any applicable Wisconsin law.

h. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E ("Privacy of Individually Identifiable Health Information").

i. The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium, received from the Plan or any Business Associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information that cannot feasibly be return or destroyed to those purposes that make the return or destruction of the information feasible.

j. The Plan Sponsor will ensure that the required adequate separation, described in detail in paragraph 4, below, is established and maintained.

4. **Adequate Separation Between the Plan Sponsor and the Plan**

a. The following persons under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a Business Associate servicing the Plan:

Employees of Wisconsin Counties Association who hold the positions of Director of Insurance Services, Director of Administration and Finance, Insurance Services Administrator, Operations Manager, Executive Administrative Assistant, Administrative Assistant.

All employees of all entities with whom the Plan has entered into Business Associate Agreements to the extent those employees perform tasks for or on behalf of the Plan and/or the Plan Sponsor.

This list includes every employee or class or employees or other persons under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The employees or other persons above shall also be given access to Plan Participants' Protected Health Information for the purpose of rendering final claim appeal determinations.

b. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

c. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

5. **Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

a. The Plan may disclose Summary Health Information (SHI) to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information (SHI) for the purpose of:

1. Obtaining premium bids for the health coverage offered under the Plan; or

2. Modifying, amending or terminating the Plan.

Summary Health Information (SHI) includes aggregated claims history, claims expenses or types of claims experienced by enrollees in the Plan. Although this information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the SHI as belonging to a particular participant.

b. The Plan may disclose enrollment and disenrollment information to the Plan Sponsor.

PROOF OF LOSS

You must provide the Plan with written proof of Your claim. Proof should be provided within 90 days after the date the claim was incurred. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless You were legally incapacitated during the period, any claim received by the Plan more than 16 months after the date the claim was incurred will not be covered under the Plan.

If the Plan is terminated, written proof of any claims incurred prior to the termination must be given to the Plan within 12 months of its termination. Any claim received by the Plan more than 12 months after it is terminated will not be covered under the Plan.

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind and any attempt to accomplish these will be void. If the Plan Administrator finds that such an attempt has been made, the Plan Administrator, at its sole discretion, may terminate the interest of the Covered Person in the payments and apply the amount of the payment to or for the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan to the extent of the payment.

REPRESENTATIONS

All representations by a Covered Person are material and relied upon in providing coverage under the Plan.

RIGHT TO NECESSARY INFORMATION

The Claims Administrator has the right to decide which facts it needs to apply and coordinate these provisions with other plans. It may get needed facts from or give them to any other organization or person without consent of the insured, but only as needed to apply these provisions. Medical records remain confidential as provided by state law. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

SECURITY

The WCA Group Health Trust, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Trust certifies to the Plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Employer under this provision;

3. Report to the Plan any security incident that the Trust becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

TERMINATION OF THE PLAN

If the Plan is terminated, the rights of the Covered Persons to benefits are limited to claims incurred and payable by the Plan before the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of Covered Persons, except that any taxes and administration expenses may be paid from the Plan assets.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, Your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the Plan will notify You of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the Plan will give its decision on the claim. If You fail to provide the information requested by the Plan, the Plan will provide You with its decision on the claim within 48 hours of the end of the period that You were given to provide the information.

If You fail to follow the Plan procedure for a Pre-Service Claim, the Plan will notify You within 24 hours of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for You to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a Plan Amendment. This will not apply if the benefit is being stopped due to the termination of the Plan.

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, Your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-Urgent Care claim. The Plan may extend this period by 15 days if You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If You fail to follow the Plan procedure for a non-Urgent Care Pre-Service Claim, the Plan will notify You within five days of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

CLAIM APPEAL PROCEDURE

A two-level appeal process is available under this Plan, followed by the Federal External Review Program. The first level of appeal is to the Claims Administrator (UMR). If You disagree with the result of the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust).

FIRST LEVEL OF APPEAL

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the Claims Administrator, for a full and fair review of the claim by the Plan;
2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of Your appeal.

A request for a review must be filed with the Claims Administrator within 180 days after receipt of the claim denial. If Your request for review is not received within 180 days, Your right to appeal the claim denial is forfeited.

If Your request for review is received within 180 days, a full and fair review of the claim will be held by the Claims Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide You with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

After the review, the Plan's decision will be made to You in writing. It will include specific reasons for the decision as well as specific references to the Plan provisions on which the decision is based. You will be notified of the Plan's decision as follows:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter timeframe;

2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter timeframe; or

3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

SECOND LEVEL OF APPEAL

If You disagree with the Plan's decision on the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust) by using the procedures outlined below:

Claim Appeal Procedure – continued

Request for Review

Upon completion of the first level of appeal, any participating Covered Employee or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim.

The written request must be submitted to the Claims Review Committee within **ninety (90) days** after receipt of the Plan's decision on the first level of appeal. The request shall be accompanied by any evidence and argument the participating Covered Employee or beneficiary wishes to present.

Send Your request to the WCA Claims Review Committee through UMR at the following address:

UMR, Inc.
Claim Appeals
P O Box 30546
Salt Lake City, UT 84130

When requesting a review, You should state the reasons You believe the denial was improper and submit any additional information, material or comments which You consider appropriate.

Review

Upon timely receipt of a request for review, the Claims Review Committee will schedule a review of your appeal. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Claims Review Committee will provide that information to You free of charge and sufficiently in advance of the due date of the response to the Your appeal. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide You with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

Decision

You will be notified of the Claims Review Committee's decision as follows, affirming, modifying or setting aside the previous decision or action:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;

2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or

3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;

2. The exclusion for experimental or investigational services or unproven services;

3. Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;

4. Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or

5. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR, Inc., or Your Employer fail to respond to Your appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither You nor UMR, Inc. or Your Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include:

1. Your specific request for an external review;

2. The Employee's name, address, and member ID number;

3. Your designated representative's name and address, when applicable;

4. The service that was denied; and

5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the adverse benefit determination. You, Your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

Federal External Review Program - continued

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a Covered Expense by the Plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or Your Employer. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;

2. All other documents relied upon by UMR, Inc. and/or Your Employer in making a decision on the case; and

3. All other information or evidence that You or Your physician has already submitted to UMR, Inc. or Your Employer.

If there is any information or evidence You or Your physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR, Inc. and/or Your Employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.