

**ST. CROIX COUNTY  
HRA HIGH DEDUCTIBLE OPTION**

**PreferredOne<sup>®</sup>**  
**ADMINISTRATIVE SERVICES**

**JANUARY 2009**

HRA High Deductible Option

The *Plan* includes several health *benefit* options, which may have different eligibility requirements and/or *benefits*. If a different *SPD* applies to certain *benefit* options under the *Plan*, you will be furnished a copy of the *SPD* that is applicable to you. This *SPD* applies only to the HRA High Deductible Option and the eligible employees enrolled for participation in this option of the *Plan*.

**As a *Plan* participant you can:**

- ◆ Continue health care coverage for *yourself* and/or *your covered dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* or *your covered dependents* may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.
- ◆ *You* should be provided a certification of *creditable coverage*, free of charge, from *your* group health plan or health insurance issuer when *you* lose coverage, when *you* become entitled to elect COBRA continuation coverage, when *your* COBRA continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage.

<p><b>Questions?</b></p>	<p><b><i>PreferredOne</i> Administrative Services, Inc. Customer Service staff is available to answer questions about <i>your</i> coverage.</b></p> <p><b>When contacting Customer Service, please have <i>your</i> identification card available. If <i>your</i> questions involve a bill, we will need to know the date of service, type of service, the name of the <i>provider</i>, and the charges involved.</b></p>						
<p><b>Telephone Numbers for Pre-certification and Pre-Service/Concurrent Care Claims</b></p>	<p><b>Monday through Friday 7:00 a.m. to 7:00 p.m. Central Standard Time</b></p> <table data-bbox="537 1010 1149 1108"> <tr> <td><b>Customer Service</b></td> <td><b>763.847.4477</b></td> </tr> <tr> <td><b>Toll free</b></td> <td><b>1.800.997.1750</b></td> </tr> <tr> <td><b>Hearing impaired individuals</b></td> <td><b>763.847.4013</b></td> </tr> </table>	<b>Customer Service</b>	<b>763.847.4477</b>	<b>Toll free</b>	<b>1.800.997.1750</b>	<b>Hearing impaired individuals</b>	<b>763.847.4013</b>
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<b>Hearing impaired individuals</b>	<b>763.847.4013</b>						
<p><b>Website</b></p>	<p><b>www.preferredone.com</b> <b>www.beechstreet.com</b></p>						
<p><b>Mailing Address</b></p>	<p><b><i>Claims</i>, appeal requests, certification, and written inquiries should be mailed to:</b></p> <p><b>Customer Service Department</b> <b><i>PreferredOne</i> Administrative Services, Inc.</b> <b>P.O. Box 59212</b> <b>Minneapolis, MN 55459-0212</b></p>						

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## I. ***Your Employer (Plan Administrator)***

Your Employer, which also serves as the *Plan Sponsor* and the *Plan Administrator*, has established the St. Croix County Employee Medical Plan (the “Employee Medical Plan”) which provides several options for medical coverage to eligible employees and to *eligible retirees*. This HRA High Deductible Option is one of the options offered through the Employee Medical Plan. It includes the HD Component and the HRA Component, which provide health care *benefits*. Hereinafter, this HRA High Deductible Option of the Employee Medical Benefit Plan is called the *Plan* or the HRA High Deductible Option. This *Plan* is “self-insured” which means that the *Plan Sponsor* pays the *claims* for *covered services* from its own assets. The *Plan* is described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Plan*. Your Employer has contracted with *PreferredOne* Administrative Services, Inc. to provide *claim* processing, pre-certification and other administrative services. However, *your* Employer is solely responsible for payment of *your* eligible *claims*.

The *Plan Administrator* in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this *Plan* is established and maintained. The *Plan Administrator* has the exclusive and final discretionary authority to revise the method of accounting for the *Plan*, establish rules, and prescribe any forms required for administration of the *Plan*. All determinations and decisions made by or on behalf of the *Plan Administrator* will be final and binding on the *Plan*, all persons covered by the *Plan*, all persons or entities requesting payment or a *claim* for *benefits* under the *Plan* and all interested parties. The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive and final binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Plan Administrator* has expressly delegated to other individuals or entities one or more fiduciary responsibilities with respect to the *Plan*.

The *Plan Sponsor*, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the *Plan*. This includes, but is not limited to, changes to *contributions*, *copayments deductibles*, *coinsurance*, *out-of-pocket limits*, *benefits* payable and any other terms or conditions of the *Plan*. The decision to change the *Plan* may be due to changes in federal laws governing welfare *benefits*, or for any other reason. The *Plan* may be changed to transfer the *Plan’s* liabilities to another plan or split this *Plan* into two or more parts.

The *Plan Administrator* has the power to delegate specific duties and responsibilities. Any reference in the *SPD* to the *Plan Administrator* is also a reference to its delegated designee. Any delegation by the *Plan Administrator* may allow further delegations by such individuals or entities to whom the delegation has been made. The *Plan Administrator* may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated, shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

If *you* are also enrolled for coverage or participation under a health flexible spending account program (health FSA account) sponsored by the Employer and a claim is eligible for reimbursement under the HRA Component and the health FSA account, such claim will be processed (approved/denied for reimbursement) as follows: (1) if *you* or *your provider* first submitted it to *TPA* under the HRA Component, it will be processed first under HRA Component and, if there is a remaining portion, *you* may then submit it under the health FSA account; or (2) if *you* first submitted it under the health FSA account it will be processed first under the health FSA account and if there is a remaining portion, *you* may then submit it under the HRA Component. *You* cannot seek reimbursement under this HRA Component for expenses reimbursed under another group plan, including a health FSA.

## II. ***PreferredOne Administrative Services, Inc. (PreferredOne, TPA)***

*PreferredOne*, as an external administrator referred to as a *third party administrator (TPA)*, provides certain administrative services, including *claim* processing services, subrogation, utilization management and complaint resolution assistance.

## III. **Introduction to *Your* Coverage**

### **Summary Plan Description (SPD)**

This *Summary Plan Description (SPD)* is *your* description of the HRA High Deductible Option of the Employee Medical Plan. **Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give *you* incomplete information regarding *your* rights and responsibilities under the *Plan*.** The *SPD* describes the *Plan’s* *benefits* and limitations for *your* health care coverage. Included in this *SPD* is a *Benefit Schedule* that states the amount payable for the *covered services*. *Benefits* are not covered for excluded services, and exclusions include, but are not limited to, health care services that are not *medically necessary* as determined by the *Plan Administrator* or its designee. Be sure to review the list of exclusions as well as the *Benefit Schedule*. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. *Benefits* are not available for *medically*

*necessary* services, unless such services are also *covered services*. The *Plan Administrator* has the sole, final and exclusive discretion to determine *benefits* available under the *Plan*.

Italicized words used in this *SPD* have special meanings and are defined at the back of this *SPD*. You should keep your *SPD* in a safe place for your future reference. Amendments that are included with this *SPD* or adopted by the *Plan Sponsor* are fully made a part of this *SPD*.

## **Administrative Services Agreement**

The signed Health Services Network Access and Administration Agreement between your Employer and the *TPA* constitutes the entire agreement between your Employer and the *TPA*. A version of the Health Services Network Access and Administration Agreement is available for inspection from your Employer.

## **Identification Cards**

The *TPA* issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, *claims* for *benefits* under the *Plan* or bills and/or invoices for your health care may be delayed or temporarily denied. You will be asked to present your ID card whenever you receive services.

## **Provider Directory**

At the time you enroll for coverage under this *Plan*, you will receive a *Provider Directory* that lists facilities and individuals who are *participating providers*, including *specialists*. If you need a directory or an update to your directory, it is available upon request through your Employer at no cost to you.

You are encouraged to develop a working relationship with a primary care *physician* to effectively manage your overall health condition and the coordination of all your health care needs. You may see specialists listed in the *Provider Directory* without obtaining a referral, however, it is a good practice to consult with your primary care *physician* initially to determine whether you require the services of a specialist.

The directory frequently changes and the *TPA* does not guarantee that a listed *provider* is a *participating provider*. You may want to verify that a *provider* you choose is a *participating provider*.

## **Services Received in a Participating Provider Facility from a Non-Participating Provider**

For services obtained through a *participating provider* facility, such as ancillary services, services from an x-ray technician, and services of an emergency room *physician*, the *participating provider* level of *benefits* applies as shown in the “*Benefit Schedule*”.

## **Case Management**

In cases where your condition is expected to be or is of a serious nature, the *TPA* may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the *Plan*. The *Plan Administrator* shall have the right to alter or waive the normal provisions of this *Plan* when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care. Under certain conditions, the *Plan Administrator* or its designee will consider other treatments for your serious *sickness* or *injury* as *eligible charges*. Such care or treatment provided will not be considered as setting any precedent or creating any future liability.

## **Conflict with Existing Law**

If any provision of this *SPD* conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

## **Privacy**

This *Plan* is subject to the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rules. In accordance with the HIPAA Privacy Rules, the *Plan* and the *TPA* acting on the *Plan’s* behalf, maintains, uses, or discloses your Protected Health Information for things like claims processing, utilization review, quality assessment, case management, and otherwise as necessary to administer the *Plan*. You can obtain a copy of the *Plan’s* Notice of

Privacy Practices (which summarizes the *Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how the *Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Plan Administrator*.

## Clerical Error

If a clerical error or other mistake occurs, that error does not deprive *you* of coverage for which *you* are otherwise eligible nor does it give *you* coverage under the *Plan* for which *you* are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or *benefit* coverage. Determination of *your* coverage will be made at the time the *claim* is reviewed. It is *your* responsibility to confirm the accuracy of statements made by the *Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and other *Plan* documents. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination.

## Right to Request Overpayments

The *Plan* reserves the right to recover any payments made by the *Plan* that were:

- made in error; or
- made to *you* or any party on *your* behalf where the *Plan* determines the payment to *you* or any party is greater than the amount payable under this *Plan*.

The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf.

## Eligibility for Other Plans

**Worker's Compensation.** The *Plan* is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

**Medicaid.** This *Plan* will not take into account the fact that an employee or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for *benefits*, or paying *claims*.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this *Plan*, payment of *benefits* under this *Plan* will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered employee to the *benefits* payment, and this *Plan* would make (or adjust applicable) payment to the appropriate *provider* to properly not take into account the existence of medical assistance or state Medicaid.

## IV. Eligibility, Enrollment and *Effective Date*

### A. Eligibility

*You* are eligible to enroll for coverage in both the HD Component and the HRA Component, if *you* are:

1. A union or non-union employee who is classified by the *Plan Sponsor* as a full-time employee regularly scheduled to work a minimum of 35 hours per week; or
2. A union or non-union employee who is classified by the *Plan Sponsor* as a part-time employee regularly scheduled to work a minimum of 20 hours per week; or
3. An eligible dependent of an eligible employee. An employee must enroll for coverage in order to enroll his or her dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both.

*You* are eligible to enroll for coverage in only the HD Component, if *you* are:

1. A former union or non-union employee who is classified by the *Plan Sponsor* as an eligible retiree according to State of Wisconsin retiree guidelines (an eligible retiree).

**Eligible dependents include a *covered employee's*:**

1. Lawful spouse, of the opposite sex and will not include a common law spouse regardless if recognized under state or country law.

2. Unmarried children, from birth through age 18, including:
  - a. biological children;
  - b. legally adopted children or children placed with *you* for legal adoption (date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.);
  - c. stepchildren who reside in *your* home for at least 6 months out of the year in an on-going parent/child relationship that is intended to continue to adulthood;
  - d. grandchildren who reside in *your* home in an on-going parent/child relationship that is intended to continue to adulthood and are dependent on *you* for a majority of their financial support and are claimed as income tax dependents on *your* federal income tax return. The grandchildren must be (1) placed in *your* legal custody; (2) legally adopted by you or placed for adoption with you; or (3) the dependent child of *your* unmarried *covered dependent* who is under age 19 or under age 25 if a regular full-time student at an accredited secondary school college or university;
  - e. a child under age 19 for whom *you* have been appointed legal guardian by a court of law;
  - f. a child covered under a valid Qualified Medical Child Support Order (QMCSO). Contact the *Plan Administrator* for assistance in obtaining information, at no cost to *you*, regarding the procedures governing QMCSO determinations. The *Plan Administrator* is responsible for determining whether or not a medical child support order is a valid QMCSO.
  
3. Unmarried dependent children from age 19 through age 24 who are enrolled as students in regular full-time attendance at an accredited secondary or post-secondary educational institution as recognized by the U.S. Secretary of Education, which is an accredited high school, university, four-year college, community college, technical school, or vocational school. In order to qualify as an eligible dependent under this provision, the student must carry the required number of credits per quarter/semester to qualify as a full-time student, as defined by the educational institution. A regularly scheduled break in classes, such as summer break or j-term, will not affect a student's full-time status as long as the student returns to school when the scheduled break ends.

A student, who by reason of *sickness, injury* or physical or mental disability documented by a *physician* and approved by the *Plan Administrator* or its designee, shall remain eligible if the student's course load is at least 60% of what is otherwise considered to be full-time by the educational institution.

A disabled student who carries a course load of less than 60% of what is otherwise considered to be full-time by the educational institution due to such disabled student's *sickness, injury* or physical or mental disability documented by a *physician*, shall be able to continue coverage from his or her date of disability until the earliest of any of the following occurs:

- a. the disabled student advises the *Plan Administrator* or its designee that he or she does not intend to return to school full-time;
- b. the disabled student becomes employed full-time;
- c. the disabled student obtains other health coverage;
- d. the disabled student marries and is eligible for coverage under the spouse's health care plan;
- e. the disabled student reaches age 25;
- f. this *Plan* is discontinued or terminated;
- g. one year has elapsed since the disabled student's continuation coverage began under this paragraph 3 and he or she has not returned to at least 60% of what is otherwise considered to be full-time by the educational institution within such year.

For purposes of this *SPD*, a student's address is considered to be the same as *your* address when attending an accredited school on a full-time basis.

4. Unmarried handicapped dependent children, after reaching the age of 19, will remain eligible for coverage provided they are:
  - a. Incapable of self-sustaining employment, because of a *physical handicap*, mental retardation, mental illness, or mental health disorder; and
  - b. Dependent on the *covered employee* for a majority of financial support and maintenance; and
  - c. Handicapped before age 19 or became handicapped after age 18 but before age 25 and while a full-time student covered as a dependent of the *covered employee*.

Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* or its designee within 31 calendar days after the *covered dependent* reaches age 19 or becomes handicapped while covered as a full-time student. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* or its designee may request proof again two years later, and each year after.

If the dependent is handicapped and 19 years of age or older at the time of the employee's enrollment, and such dependent received health coverage through the employee within the 60 day period immediately preceding the employee's enrollment for coverage under this *Plan*, then the *employee* may enroll the handicapped dependent only if the *employee* provides the *Plan* with proof that such dependent meets the handicapped dependent requirements within 31 days of the initial enrollment. A handicapped *covered dependent* will be eligible for coverage as long as he or she continues to be handicapped and dependent on the *covered employee*, unless coverage otherwise terminates under this *Plan*.

## **B. Enrollment and Effective Date**

When *you* enroll in this *Plan*, *you* enroll in both the HD Component and the HRA Component. *You* cannot enroll only in one component; provided, however, that *eligible retirees* are only eligible to enroll only in the HD Component.

**New Enrollment.** The eligible employee must make written application to enroll himself or herself and any eligible dependents, and pay any required *contribution*, within 31 calendar days of the date the employee first becomes eligible. Coverage will take effect on the first day of the month coinciding with or immediately following a 30 day *waiting period* following the employee's date of hire.

**Late Enrollment.** If *you* do not enroll within 31 calendar days of the date *you* first become eligible, *you* may enroll subject to any limitations under the *Plan*. *Your* coverage will take effect on the first day of the month following receipt of the completed written application.

### **Reinstatement of coverage following inactive status:**

- If *your* coverage under the *Plan* was terminated after a period of layoff, and *you* are now returning to work, *your* coverage is effective the first of the calendar month following completion of a 30-day *waiting period*.
- If *your* coverage under the *Plan* was terminated after a period of medical leave of absence or an approved non-medical leave of absence, *your* coverage is effective immediately on the day *you* return to work.
- If *your* coverage under the *Plan* was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work.

**Special Enrollment Period for Employees and Dependents.** If *you* are an eligible employee or an eligible dependent of an eligible employee but not enrolled for coverage under this *Plan*, *you* may enroll for coverage under the terms of this *Plan* if all of the following conditions are met:

1. *You* were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. The eligible employee stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Employer required a statement at such time and provided the employee with notice of the requirement and the consequences of such requirement at the time;
3. *Your* coverage described in 1. above was:
  - a. Terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
  - b. Terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer *contributions* toward such coverage were terminated; and
4. The eligible employee requested such enrollment not later than 31 calendar days after the date of exhaustion of coverage described in 3.a. above, or termination of coverage or employer *contributions* described in 3.b. above.

**Special Enrollment Period for New Dependents Only.** New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and
2. The employee is eligible for coverage under this *Plan*; and
3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This *Plan* shall provide a dependent special enrollment period during which the person may be enrolled under this *Plan* as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this *Plan*. In the case of marriage, the employee, the spouse and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and
4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage shall begin on the later of:
  - a. The date dependent coverage is made available under this *Plan*; or
  - b. The date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in 3. above.

**Effective April 1, 2009. Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants.** If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid plan or a state CHIP and that coverage is terminated as a result of loss of eligibility, then the eligible employee may request enrollment in the *Plan* on behalf of him/herself and/or his/her eligible dependents. Such request must be made within 60 days of the date the employee's and/or his/her dependent's coverage is terminated from such state plans.

If an eligible employee and/or his/her eligible dependents become eligible for a premium-assistance subsidy under the *Plan* through a state Medicaid plan or a state CHIP (if applicable), then the eligible employee may request enrollment in the *Plan* on behalf of him/herself and/or his/her eligible dependents. Such request must be made within 60 days of the date the employee and/or his/her dependents are determined to be eligible for the subsidy under such state plans.

**Note:** Other dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the birth or adoption of a child.

## V. HRA Component Provisions for Employees (and not Retirees)

**HRA Account:** A separate HRA Account will be established for each *subscriber* for record keeping and administration purposes. At the beginning of each *calendar year*, *your* HRA Account will be credited with the Employer *contributions*, *if any*, that *your* Employer allocates to *you* for such *calendar year* based on the coverage level (employee only or family) *you* selected under the *Plan*. *You* do not actually or constructively receive the Employer *contributions*, and money is not actually deposited in *your* HRA Account. Employer *contributions* are available only to reimburse *eligible charges*. *Your* HRA Account will decrease during the *calendar year* whenever a payment is made for *eligible charges you incur* during the *calendar year*.

**Payment of Post-Service Claims:** After the effective date of the *Plan*, payments may be made weekly from *your* HRA Account for *post-service claims incurred* for *eligible charges* during the *calendar year* and while *you* are enrolled in this *Plan*. The full amount in *your* HRA Account will be available to *you* at any time during the *calendar year* for payment of *eligible charges*, reduced by any prior payments made from *your* HRA Component during the *calendar year*.

The HRA Component is intended to receive claims information directly from the HD Component. A *post-service claim* is first processed for payment by the HD Component. To the extent any portion of the *post-service claim* is not paid by the HD Component due to the *deductible* under the HD Component, the HD Component will transmit that information directly to the *TPA*. If for any reason a *post-service claim* is not automatically forwarded to the *TPA* by the HD Component on *your* behalf, *you* may submit the *post-service claim* to the *TPA* for payment under this HRA Component. The *TPA* will make the payment for *eligible charges* from the remaining amount of *your* Employer *contribution* based on the *deductible* information shown on the Explanation of Benefits (EOB) which the *TPA* receives from the HD Component.

*Prescription drug* payments are not reimbursable under the HRA Component.

Payments for *eligible charges* can only be made up to the balance in *your* HRA Account. Payment cannot be made for any: (1) *eligible charges* that arise before the effective date of this HRA Component, (2) *eligible charges* that arise before *you* become a participant in this HRA Component, (3) *eligible charges incurred* after *you* terminate

employment, (4) *eligible charges incurred* during a period of time when *you* have terminated coverage and then have reenrolled into this HRA Component within the same *calendar year*, or (5) otherwise cease to be eligible for coverage under this HRA Component.

*Participating providers* will usually submit *post-service claims* for *you*. Payment of the *post-service claim* from a *participating provider* will be sent to the *participating provider*. When receiving services from a *non-participating provider* *you* or the *non-participating provider* may submit the *post-service claim*. Payment of the *post-service claim* from a *non-participating provider* may be either sent to *you* or the *non-participating provider*.

An *eligible charge* is *incurred* when the *covered person* is provided services which give rise to *eligible charges*, not when the services are billed or paid.

**Maximum Amount:** The maximum amount *you* may receive from *your* HRA Account per *calendar year* is the Employer *contribution*, if any, that *your* Employer makes for *you* for the *calendar year* plus any carryover amounts that remain in *your* HRA Account. This maximum amount applies on an aggregate basis (if the family option is elected) to the entire family unit which includes *you* and *your covered dependents*, or one individual may use the entire family amount during the *calendar year*. To receive a payment from *your* HRA Account for a manually submitted paper claim, the *eligible charges* must be at least \$50.

**Carryover of HRA Account:** Except as is otherwise set forth in “HRA Account Forfeitures and Spend Down HRA for *Eligible Retirees*” with respect to *eligible retirees*, the unused portion of *your* HRA Account (if any) at the end of the *calendar year* shall be carried over to the next *calendar year* and remain credited to *your* HRA Account. The Employer *contribution* for the next *calendar year* shall be added to the carryover amount. Unless *you* are an *eligible retiree*, unused *contributions* shall not carry over to the next *calendar year* if *your* employment ends or *you* cease to be eligible for coverage under the HRA Component before the carryover *calendar year* begins.

**Payment from *Your* HRA Account after Termination of *Your* Coverage:** When *your* coverage ends, *you* are still eligible for reimbursement of *eligible charges* that are *incurred* prior to *your* coverage termination date, provided amounts remain in *your* HRA Account.

**HRA Account Forfeitures for Employees:** When *your* coverage terminates under the HRA Component (for a reason other than *you* becoming an *eligible retiree*) and the claims submission period has ended, any amount remaining in *your* HRA Account at the end of the *calendar year* that coincides with or follows *your* coverage termination date will be forfeited at the end of the last day of that *calendar year*. If some or all *your* HRA Account is forfeited, *you* will have no recourse under any circumstances to such forfeited balance. The *Plan Administrator* may use such forfeitures to offset the cost of administering this HRA Component. If *you* again enroll in the *Plan* and the HRA Component in the future, *your* forfeitures will not be restored.

**HRA Account Forfeitures and Spend Down HRA for *Eligible Retirees*:** If *you* become an *eligible retiree* as defined in “Eligibility, Enrollment and *Effective Date*,” *you* are no longer eligible to participate in or receive Employer *contributions* under the HRA Component, as of the last day of the month in which *you* retire. When the claims submission period ends, the unused balance in *your* HRA Account shall be forfeited. However, fifty percent (50%) of *your* HRA Account (*your* “spend down amount”) will be transferred to a separate “spend down HRA” for *you* that will be administered by another third party administrator. The “spend down amount” will remain available for payment of future medical expenses and medical premiums, and *you* may request reimbursement under the “spend down HRA,” according to its separate terms. This spend down HRA is available to *you* as an alternative to any COBRA or state continuation rights that *you* may have, and only if *you* do not elect such continuation coverage.

**Employer *Contributions* for Eligible Employees:** *Your* Employer, in its discretion, may make a non-elective *contribution* to *your* HRA Account as of the effective date of *your* enrollment for coverage under the *Plan* and, in its discretion, may also make a non-elective contribution to *your* HRA Account on the first day of each [plan] *calendar year* thereafter for which *you* remain enrolled in *Plan*. If the effective date of *your* enrollment in the HRA Component is after January 1<sup>st</sup> of a *calendar year*, the Employer will prorate any contribution it makes to *your* HRA Account during that *calendar year*. The *contribution* amount, when allocated on *your* behalf, will be credited and applied to *your* HRA Account. The *contribution* for each applicable coverage level will be determined and communicated by the Employer prior to the start of each applicable *calendar year*, and may change from *calendar year* to *calendar year*.

The Employer will not contribute to the HRA Accounts of *eligible retirees*, except to the extent required by law when the *eligible retiree* has contributions available to spend down under “HRA Account Forfeitures and Spend Down HRA for *Eligible Retirees*” and elects continuation coverage under applicable federal or state continuation law with respect to his or her HRA Account.

**Not a Trust Account:** The HRA Account is a bookkeeping account only. Employer *contributions* are paid from the Employer's general assets. *You* are not entitled to, nor have any interest in, any assets of *your* Employer upon *your* termination of employment, except only to the *benefits* payable under this HRA Component.

**Amendment or Termination of HRA Component:** The Employer has the authority to, and in its discretion, may amend or terminate the HRA Component in the future. *You* will be notified of changes to the terms and provisions of this *SPD*.

**Tax Deductions:** *You* cannot claim any medical expense on *your* income tax form for which *you* have received reimbursement under this HRA Component. In addition, *you* may not receive payment under this HRA Component for any medical expense that has been or will be submitted or paid under any other similar plan.

## VI. **Benefit Schedule**

*You are required to pay any copayment, deductible and coinsurance amount. Benefits listed in this Schedule are according to what the Plan pays. Any amount of coinsurance you must pay to the provider is based on 100% of eligible charges less the percentage covered by the Plan. Plan payment begins after you have satisfied any applicable copayments, deductibles and coinsurance.*

*Discounts negotiated by the TPA with providers may affect your coinsurance amount. This Plan may pay higher benefits if you choose a participating provider.*

### **A. Pre-Certification Requirement and Prior Authorization**

**Pre-certification or prior authorization of services does not guarantee either payment or the amount of payment. Eligibility for, and payment of, benefits are subject to all of the terms of the SPD. Please read the entire SPD to determine which other provisions may also affect benefits. The TPA's Utilization Management Department only certifies the service as medically necessary.**

**Pre-Certification Requirement:** Pre-certification is a screening process that permits early identification of situations where case management would be beneficial, or medical management is required, and to determine *medical necessity*. It is *your* responsibility to be sure that *you* or *your provider* calls Customer Service before certain services are performed.

<b>Provision</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Pre-Certification Penalty</b>	None.	The <i>deductible</i> will apply to non-precertified charges.

Pre-certification through the *Plan Administrator* or its designee is required. Failure to pre-certify the following medical services may result in a reduction of *benefits* based on the pre-certification penalty listed above:

- All inpatient admissions including *skilled nursing facility, rehabilitation, hospital, etc.*;
- *Transplant services*;
- Medication management; and
- *Bariatric surgery*.

Expenses *you* pay for pre-certification penalties will not apply towards satisfaction of the *out-of-pocket limit*. If *you* have questions about pre-certification and when *you* are required to obtain it, please contact Customer Service.

**Prior Authorization:** It is recommended that certain services be authorized to determine *medical necessity* in advance by the *Plan Administrator* or its designee. Pre-certification penalties do not apply. If *you* have questions about prior authorization, please contact Customer Service.

Prior authorization is suggested before the following medical services are received:

- Drugs or procedures that may be *cosmetic*;
- Durable medical equipment (DME) and prosthesis that may exceed \$1,000;
- Home health care;
- Hospice services;
- Non-*emergency* transportation;
- Outpatient surgeries;
- Outpatient mental health and substance related services;
- Physical therapy, occupational therapy, speech therapy, and other therapies; and
- Pain therapy programs.

Should the state of Minnesota and/or the Minneapolis/St. Paul seven-county metropolitan area be declared subject to a pandemic alert, the *Plan* may suspend pre-certification requirements, prior authorization requirements, and other services as may be determined by the *Plan Administrator* or its designee.

**NOTE: This is a non-ERISA (Employee Retirement Income Security Act) plan. The Employer is not required to adopt *claims* procedures that comply with ERISA. However, for ease to *claims* administration, the Employer voluntarily designed the *Plan* and *SPD* to follow *claims* procedures similar to those required for ERISA-governed plans. The Employer reserves the right to amend the *Plan* at any time, including the right to amend the *claims* procedures for the *Plan*.**

### **Pre-Certification Procedure for Non-Acute Care Pre-Service *Claims***

Non-acute care pre-service *claims* are *claims* for non-acute care services that require pre-certification and are submitted in accordance with the pre-service *claim* filing procedures for the *Plan*.

**Filing Procedure for Non-Acute Care Pre-Service *Claims*.** To request pre-certification and file a non-acute care pre-service *claim*, a phone call must be made to Customer Service at least 7 calendar days before the date services requiring pre-certification are provided and all essential data elements must be supplied. An expedited review is available if *your* attending *provider* believes *your* medical condition warrants it. Please refer to the subsection below entitled “Essential Data Elements for Pre-Service *Claims*” for the list of essential data elements that are required to file a pre-service *claim*. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified within 5 calendar days. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives a pre-certification request submitted in accordance with the *Plan*'s filing procedures.

If *your* attending *provider* requests pre-certification on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three (3) business days from the *Plan Administrator* or its designee's notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services that do not require pre-certification will not be treated as a *claim* under the *Plan*.

**Initial *Benefit* Determination of Non-Acute Care Pre-Service *Claims*.** *You* and *your* attending *provider* will be notified of the *TPA*'s initial *benefit* determination within 15 calendar days after receipt of a pre-certification request submitted in accordance with the *Plan*'s filing procedures, provided the *TPA* has all necessary information.

If the *TPA* does not have all information it needs to make an initial *benefit* determination, it may extend the time period for the initial *benefit* determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 15-calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. The *TPA* will notify *you* of its initial *benefit* determination within 15 calendar days after the earlier of the *TPA*'s receipt of the requested information or the end of the time period specified for *you* to provide the requested information. The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA*'s control.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* pre-certification request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

**Note:** Refer to the subsection entitled “*Claim Appeals Process*” for details on submission of appeals.

### **Expedited Pre-Certification Procedure for Acute Care Pre-Service *Claims***

Acute care services are services needed when a delay in treatment could seriously jeopardize *your* life or health, or the ability to regain maximum function or, in the opinion of *your* attending *provider*, could cause severe pain. An expedited initial *benefit* determination will be made for *claims* for services that require pre-certification and are submitted in accordance with the pre-service *claim* filing procedures for the *Plan*, if *your* attending *provider* believes *your* medical condition warrants acute care services.

**Filing Procedure for Acute Care Pre-Service Claims.** To request expedited pre-certification and file an acute care pre-service *claim*, a phone call must be made to Customer Service before the date services requiring pre-certification are provided and all essential data elements must be supplied. Please refer to the subsection below entitled “Essential Data Elements for Pre-Service *Claims*” for the list of essential data elements that are required to file a pre-service *claim*. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified within 24 hours. Please note that the time periods for making an expedited initial *benefit* determination begin when Customer Service receives a pre-certification request submitted in accordance with the *Plan’s* filing procedures.

If *your* attending *provider* requests pre-certification on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three (3) business days from the *Plan Administrator* or its designee's notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services that do not require pre-certification will not be treated as a *claim* under the *Plan*.

**Expedited Initial Benefit Determination of Acute Care Pre-Service Claims.** An expedited initial *benefit* determination will be provided by *TPA* to *you* and *your* attending *provider* as quickly as *your* medical condition requires, but no later than 72 hours following receipt of a pre-certification request submitted in accordance with the *Plan’s* filing procedures. If the *TPA* does not have all information it needs to make an initial *benefit* determination, *you* will be notified within 24 hours. *You* will then have 48 hours, or longer time as granted to *you* in the notification, to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. *You* will be notified of the initial *benefit* determination within 48 hours after the earlier of the *TPA’s* receipt of the requested information or the end of the time period specified for *you* to provide the requested information.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* pre-certification request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

**Note:** Refer to the subsection entitled “*Claim Appeals Process*” for details on submission of appeals.

#### **Essential Data Elements for Pre-Service Claims (including Concurrent Care Claims)**

*You* or *your* attending *provider* must submit at least the following essential data elements when calling Customer Service to request pre-certification and file a pre-service *claim* (or requesting to extend a previously pre-certified treatment and file a concurrent care *claim*):

- The identity of the *covered person* and *provider* of services;
- The date(s) of services;
- A specific medical diagnosis; and
- A specific treatment, service or product for which pre-certification approval (or extended treatment) is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling Customer Service. If *you* or *your* attending *provider* have not submitted the pre-certification (or extended treatment) request in accordance with the *Plan’s* filing procedures for pre-service *claims*, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified within applicable timeframes.

## Procedure for Concurrent Care Claims

**Filing Procedure for Concurrent Care Claims.** If an ongoing course of treatment was pre-certified by the *Plan Administrator* or its designee for a specified period of time or number of treatments and *you* or *your* attending *provider* request to extend acute care services, *your* extension request and concurrent care *claim* must be submitted in accordance with the filing procedure for acute care pre-service *claims*, as described above. If an ongoing course of treatment was pre-certified by the *Plan Administrator* or its designee for a specified period of time or number of treatments and *you* or *your* attending *provider* request to extend non-acute care services, *your* extension request and concurrent care *claim* must be submitted in accordance with the filing procedure for non-acute care pre-service *claims*, as described above. If *you* or *your* attending *provider* have not submitted the extension request in accordance with the *Plan's* filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified: within 24 hours in the case of a request to extend acute care services, and within 5 calendar days in the case of a request to extend non-acute care services. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives an extended treatment request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests extended treatment on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three (3) business days from the *Plan Administrator* or its designee's notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services or extended treatments that do not require pre-certification will not be treated as a *claim* under the *Plan*.

**Initial Benefit Determination of Concurrent Claims.** If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and *you* request to extend acute care services, the *TPA* will make the initial *benefit* determination on *your* extended treatment request within 24 hours following receipt of a properly filed extended treatment request, provided *your* request is made at least 24 hours before the end of the approved treatment. If a properly filed request for extended treatment is not made at least 24 hours before the end of the approved treatment, *your* request will be treated as a pre-certification request for acute care services and handled in accordance with the expedited pre-certification procedures outlined above for such services.

If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and *you* request to extend non-acute care services, *your* request will be treated as a pre-certification request for non-acute care services and handled in accordance with the pre-certification procedures outlined above for such services.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* concurrent care *claim* and extended treatment request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

**Note:** Refer to the subsection entitled “*Claim Appeals Process*” for details on submission of appeals.

Provision	Participating Provider	Non-Participating Provider
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<b>B. HD Component Deductible</b>	The participating providers deductible amount applies to the non-participating provider deductible amount, but the non-participating provider deductible amount does not apply to the participating provider deductible amount.	
	\$1,500 single/family per calendar year,	\$3,000 single/family per calendar year.

<b>C. HRA Reimbursement of Deductible (Employer HRA Contribution)</b>	\$1,400 single/family per calendar year.
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For *eligible charges* that are applied to the HD Component *deductible* amounts, a *covered person* will be paid up to the amounts shown in the HRA Reimbursement of *Deductible* provision above.

Once a *covered person* incurs *eligible charges* equal to the HD Component *deductible* amounts shown above, the *Plan* will begin to pay *benefits* for the rest of the *calendar year* under the HD Component.

When members of *your* family have *incurred eligible charges* equal to the HD family *deductible* amount shown above, all family members are deemed to have satisfied their individual *deductibles* for that *calendar year*. *You* must submit copies of bills for *eligible charges* used to satisfy the HD *deductible* to the *TPA*. Expenses *you* pay for *prescription drug* payments will not apply to the HD Component *deductible* and are not reimbursable under the HRA Component.

The amount (if any) not paid under the HRA Component during the *calendar year* for *eligible charges incurred* that same *calendar year* will be rolled over and added to the *contribution* amount for the next *calendar year* for payment of *eligible charges* during that next *calendar year*.

**Carryover Deductible:** *Eligible charges incurred* in the last three months of a *calendar year* and applied toward *your* current year's *deductible*, will also apply to *your deductible* for the next *calendar year*.

<b>D. Out-of-Pocket Limit</b>	The participating providers out-of-pocket limit applies to the non-participating provider out-of-pocket limit, but the non-participating provider out-of-pocket limit does not apply to the participating provider out-of-pocket limit.	
	\$1,500 single/family per calendar year	\$4,000 single/family per calendar year

After *you* have met the *out-of-pocket limit* per *calendar year* for *coinsurance* and *deductibles*, the *Plan* covers 100% of all other *eligible charges incurred*. *You* pay any amount greater than the *out-of-pocket limit* if any *benefit* maximum or the lifetime maximum is exceeded. Expenses *you* pay for pre-certification penalties and *prescription drug* payments will not apply towards satisfaction of the *out-of-pocket limit* and are not reimbursable under the HRA Component.

<b>E. Lifetime Benefit Maximum</b>	No maximum.	\$2,000,000 per <i>covered person</i> for services received from <i>non-participating providers</i> .
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The lifetime benefit maximum is the cumulative amount per *covered person* for all *eligible charges* while covered under any and all plans, or options providing health care *benefits* offered by the Employer.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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## **F. Ambulance Services**

100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>participating provider deductible</i> .
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The *Plan* covers ambulance service to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance transport to the nearest *hospital* that is able to render *medically necessary* care, is covered only when the condition is an acute medical *emergency* and is authorized in advance by a *physician*. Prior authorization is suggested for non-*emergency* transfers by ambulance when medical supervision is required en route.

The *Plan* also covers *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician*.

### **Exclusions:**

- Please see the section entitled “Exclusions.”
- Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

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## **G. Chiropractic Services**

100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
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Coverage includes chiropractic services to treat acute musculoskeletal conditions, by manual manipulation therapy. Diagnostic services are limited to *medically necessary* radiology. Treatment is limited to conditions related to the spine or joints.

### **Exclusions:**

- Please see the section entitled “Exclusions.”
- Routine maintenance chiropractic care.
- Acupuncture, except for chronic pain programs.
- Blood, urine or hair analysis related to chiropractic services
- Ultrasound, MRI, EMG, waveform, and nuclear medicine diagnostic studies related to chiropractic services.
- Manipulation under anesthesia related to chiropractic services.
- Homeopathic/holistic services related to chiropractic services.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**H. Dental Services**

**(Medically necessary services only)**

The *Plan Administrator* or its designee considers dental procedures to be services rendered by a *dentist* or dental *specialist* to treat the supporting soft tissue and bone structure.

Accidental Dental Services	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Outpatient Services and Hospitalization for Dental Care	See “Office Visits” and “Hospital Services”.	See “Office Visits” and “Hospital Services”.

**Accidental Dental Services.** Treatment and repair for services required due to an accidental *injury* must be completed within 12 months from the date of the *injury*. The *Plan* covers services to treat and restore damage done to a sound, natural tooth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss.

**Medically Necessary Dental Services.** The *Plan* covers dental services, limited to dental services required for treatment of an underlying medical condition, e.g. surgical extraction of wisdom teeth, removal of teeth to complete radiation treatment for cancer of the jaw, cysts, lesions and removal of a tooth root without removal of the whole tooth, and root canal therapy.

If *you* are enrolled under both this medical *Plan* and the dental plan offered by the *Plan Sponsor* and *you incur* dental services covered by both this medical *Plan* and the dental plan offered by the *Plan Sponsor*, *benefits* for *eligible expenses* will be paid under this medical *Plan* first. The dental plan offered by the *Plan Sponsor* will pay secondary to this medical *Plan*.

**Medically Necessary Hospitalization for Dental Care.** *Eligible charges* are those *incurred* by a *covered person* who: (1) is a child under age 5; (2) is severely disabled; or (3) has a medical condition, and requires hospitalization or general anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or dental *specialist* professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician, dentist* or dental *specialist*.

**Exclusions:**

- Please see the section entitled “Exclusions.”
- Dental services covered under *your* dental plan, except as stated in this Dental Services provision.
- Preventive dental procedures.
- Dental services, orthodontia and all associated expenses, except as stated in this section.
- Services for cracked or broken teeth that result from biting, chewing, disease or decay.
- Dental implants.
- Dental services related to periodontal disease.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**I. Durable Medical Equipment (DME), Services And, Prosthetics**

	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Diabetic supplies	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	80% of <i>eligible charges</i> after the <i>deductible</i> .

The *Plan* covers certain equipment and services, and nutritional formulas and enteral feedings, which may include; amino-acid based formulas, other oral nutritional and electrolyte substances; and special dietary for treatment of phenylketonuria (PKU); ordered or prescribed by a *physician* and provided by DME/prosthetic vendors. For verification of eligible equipment and supplies, call Customer Service. Payment is limited to the most cost-effective and *medically necessary* alternative. *Plan* payment for rental shall not exceed the purchase price unless the *Plan* has determined that the item is appropriate for rental only. The *Plan Administrator* or its designee reserves the right to determine if an item will be approved for rental or purchase.

**Exclusions:**

- Please see the section entitled “Exclusions.”
- Any durable medical equipment or supplies not listed as eligible on the *Plan’s* durable medical list, or as determined by the *Plan Administrator* or its designee.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
- Duplicate or similar items.
- Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation.
- Hearing aids, devices to improve hearing and related fittings, except for children under age five and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts and car carrier.
- Over-the-counter orthotics and appliances.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the *Plan Administrator* or its designee determines are not eligible for coverage, except for the treatment of PKU.
- Charges for sales tax, mailing or delivery.
- Wigs.
- Durable medical equipment, orthotics, and prosthetics that are necessary for activities beyond activities of daily living (ADL’s).
- Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**J. Emergency Room Services**

100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>participating provider deductible</i> .
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You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for “on call” and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone *your physician* or the clinic where *you* normally receive care. A *physician* will advise *you* how, when and where to obtain the appropriate treatment.

**Note:** Non-*emergency* services received in an emergency room are not covered. If *you* choose to receive non-*emergency* health services in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under “Definitions”.

Covered *hospital* services are subject to all of the *benefit* limitations set forth in this *SPD*. To receive coverage under this part, *you* or *your* representative must notify Customer Service of admittance within 48 hours or as soon as reasonably possible, when medically stable.

**Exclusions:**

- Please see the section entitled “Exclusions.”
- Non-*emergency* services received in an emergency room.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**K. Home Health Services**

Coverage is limited to a maximum of 40 visits (2 hours of service = 1 visit) per *covered person* per *calendar year*.  
Limit does not apply to TPN/IV therapy.

Intermittent skilled care and home health care as an alternative to *hospital confinement* or *skilled nursing facility* care

100% of *eligible charges* after the *deductible*.

80% of *eligible charges* after the *deductible*.

The *Plan* covers skilled home health services that are directed by a *physician* and received from a licensed Home Health Care Agency. Services may include: *skilled care*; physical therapy; occupational therapy; speech therapy; respiratory therapy, and other *medically necessary* therapeutic services that are rendered in *your* home.

In order for services to be received in *your* home, *you* must be *homebound*, or the *Plan Administrator* or its designee must determine the services are medically appropriate and the most cost effective to the *Plan*.

A service shall not be considered *skilled care* merely because it is performed by, or under the direct supervision of, a licensed registered nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed registered nurse, the service shall not be regarded as *skilled care*, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of “blended” services (i.e., services that include skilled and non-skilled components) is covered under the *Plan*.

**Exclusions:**

- Please see the section entitled “Exclusions.”
- Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
- Services provided as a substitute for a primary caregiver in the home.
- Services that can be performed by a non-medical person or self-administered.
- Home health aides, unless determined to be *medically necessary* by the *Plan Administrator* or its designee.
- Services provided in *your* home for convenience.
- Services provided in *your* home due to lack of transportation.
- *Custodial care*.
- Services at any site other than *your* home.
- Recreational therapy.
- Services rendered by *providers* unlicensed or not certified by the appropriate state regulatory agency.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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## L. Hospice Care

100% of *eligible charges*  
after the *deductible*.

80% of *eligible charges*  
after the *deductible*.

The *Plan* covers hospice services for terminally ill patients in a hospice program. The patient must meet the eligibility requirements of the program, and elect to receive services through the hospice program. The services will be provided in the patient’s home or hospice center, with inpatient care available when *medically necessary*. Hospice services are in lieu of curative or restorative treatment.

**Eligibility.** In order to be eligible to be enrolled in the hospice program, *you* must:

- be terminally ill with *physician* certification of 6 months or less to live; and
- have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

*You* may withdraw from the hospice program at any time.

Hospice services include the following services provided by Medicare-certified hospice program *providers*, if authorized in advance by the *Plan Administrator* or its designee and provided in accordance with an approved hospice treatment plan:

- Part-time care provided in *your* home by an interdisciplinary hospice team (which may include a *physician*, nurse, social worker, and spiritual counselor) and home health aide services;
- One or more periods of continuous care provided in *your* home or in a setting that provides day care for pain or symptom management by a registered nurse, licensed practical nurse, or home health aide, when *medically necessary* as determined by the *Plan Administrator* or its designee;
- *Medically necessary* inpatient services;
- Respite care must be authorized in advance to give *your* primary caregivers (i.e., family members or friends) rest and/or relief when necessary. The period of *respite care* is limited to 30 calendar days while enrolled in the hospice program;
- *Medically necessary* medications for pain and symptom management;
- Durable medical equipment when authorized in advance and determined by the *Plan Administrator* or its designee to be *medically necessary*.

### Exclusions:

- Please see the section entitled “Exclusions.”
- Services provided by *your* family or a person who shares *your* legal residence.
- Respite or rest care except as specifically described in this section.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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### **M. Hospital Services**

<b>Outpatient Hospital Services, Ambulatory Care or Surgical Facility Services</b>	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Services for prenatal care	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.
Services for routine screening procedures for cancer, including: mammograms, pap smears, bone density, and prostate specific antigen (PSA), and colonoscopies.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.
<b>Inpatient Hospital Services</b>	Separate <i>deductible</i> amounts are required for a mother and newborn child unless <i>you</i> pre-certify services.	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .

Notify the *TPA* of an admission to a *hospital* within 48 hours or as soon as reasonably possible after an *emergency*. For non-*emergencies*, a phone call must be made to Customer Service no less than 7 calendar days prior to the date of services.

**Outpatient Hospital, Ambulatory Care or Surgical Facility Services.** The *Plan* covers services and supplies authorized by a *physician* for the diagnosis or treatment of *sickness* or *injury* on an outpatient basis:

- Use of operating rooms or other outpatient departments, rooms or facilities;
- General nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related outpatient services;
- Laboratory tests, pathology and radiology;
- *Physician* and other professional medical and surgical services rendered while an outpatient;
- Elective abortion, and
- Elective sterilization (unless performed in an office visit).

The *Plan* also covers *preventive health care* services performed in an outpatient *hospital* setting. These preventive services will be covered as indicated under *Preventive Health Care Services* in the Office Visit and *Urgent Care Center Visits* section of this *SPD*.

**Inpatient Hospital Services.** The *Plan* covers services and supplies authorized by a *physician* for the treatment of acute *sickness* or *injury* that requires the level of care only available in an acute care facility. Inpatient *hospital* services include, but are not limited to:

- Room and board;
- The use of operating rooms, intensive care facilities, newborn nursery facilities;
- General nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related *hospital* services;
- *Physician* and other professional medical and surgical services;
- Laboratory tests, pathology and radiology;
- For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient; and
- *Bariatric surgery*.

The *Plan* covers a semi-private room. *Benefits* for a private room are available only when the private room is *medically necessary* for a *sickness* or *injury* or if it is the only option available at the admitted facility. If *you* choose

a private room when it is not *medically necessary*, *Plan* payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

If *you* were incapacitated in a manner that prevented *you* from providing the required notice described under “Emergency Room Services”, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: (1) *you* are physically or mentally unable to provide the required notice; and (2) *you* are unable to provide the notice through another person.

### **Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act**

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 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or health 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.

Also, under federal law, group health plans or health issuers may not set the level of *benefits* or out-of-pocket costs so that any later portion of the 48-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 group health plan or health 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 48 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 pre-certification as described in the pre-certification provisions of the *Benefit Schedule*.

### **Exclusions:**

- Please see the section entitled “Exclusions”.
- Travel, transportation, other than ambulance transportation, or living expenses.
- Hospitalization, transportation, supplies, or medical services, including *physicians’* services furnished by the United States Government or by an institution operated by the United States Government, unless payment is required in accordance with applicable law.
- Nutritional counseling, except when provided during a *confinement* or for the diagnosis and treatment of diabetes, or an eating disorder.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Non-*emergency* ambulance service from *hospital to hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
- Services and/or drugs to treat conditions that are *cosmetic* in nature.
- Orthoptics.
- Refractive surgery (e.g. lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Services and/or surgery and associated expenses for gender reassignment.
- Genetic testing and associated services when done as a screening test to predict whether *you* may be a carrier of a specific *sickness* when *you* are not diagnosed with the specific *sickness* by a *physician* or *you* are not at high risk for the specific *sickness* as confirmed by a *physician*. This exclusion does not apply to *medically necessary* prenatal fetal or maternal genetic testing (e.g. amniocentesis, chorionic villous sampling) when done as a part of the care of a *covered person’s* pregnancy.
- Homeopathic medicine, acupuncture except for chronic pain programs, hypnosis, and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Autopsies, unless requested by the *Plan Administrator* or its designee.
- Cochlear implants, except for children under age five and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
- All weight loss programs, including, but not limited to, consultations, laboratory services, testing, nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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## N. Infertility Services

Coverage for treatment of infertility (not including *prescription drugs*) is limited to a maximum *Plan* payment of \$10,000 per *covered person* per lifetime. *Prescription drugs* prescribed for the treatment of infertility are limited to 6 cycles per *covered person* per lifetime.

100% of *eligible charges*  
after the *deductible*.

80% of *eligible charges*  
after the *deductible*.

The *Plan* covers professional services for the diagnosis and treatment of infertility, tests, facility charges and laboratory work related to *covered services* (such as but not limited to, diagnostic radiology, laboratory services, semen analysis and diagnostic ultrasounds). *Benefits* for covered infertility treatment (i.e., artificial insemination (AI), intrauterine insemination (IUI) procedures and/or super-ovulatory drugs) is limited to a total of 6 cycles per *covered person* per lifetime.

A cycle is defined as one partial or complete fertilization attempt extending through the implantation phase only. Any attempt using artificial insemination, intrauterine insemination, and/or *prescription drugs* will be applied to the 6-cycle maximum. If the patient abandons a treatment regimen before the cycle is complete, the partial cycle is counted as one of the 6 cycles.

### Exclusions:

- Please see the section entitled “Exclusions”.
- Charges for treatment in excess of \$10,000 (not including *prescription drugs*.)
- Artificially assisted technology.
- In vitro fertilization.
- Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
- Surrogate pregnancy.
- Sperm banking.
- Embryo and egg storage.
- Reversal of voluntary sterilization.
- Donor sperm.
- More than 6 cycles for AI and/or IUI and/or *prescription drugs* unless a pregnancy is attained and the *benefit* is renewed.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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## O. Mental Health And Substance Related Services

Outpatient Office Visits	Coverage is limited to 20 visits per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Outpatient <i>Hospital Services, Day Treatment Services</i> and Transitional Care	Coverage is limited to 15 visits per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Inpatient <i>Hospital Services</i>	Coverage is limited to 30 days per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .

### Substance Related Services

Outpatient Office Visits	Coverage is limited to a maximum <i>Plan</i> payment of \$1,800 per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Outpatient <i>Hospital Services, Day Treatment Services</i> or Transitional Care	Coverage is limited to a maximum <i>Plan</i> payment of \$2,700 per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Inpatient <i>Hospital Services</i>	Coverage is limited to a maximum <i>Plan</i> payment of \$6,300 per <i>covered person</i> per <i>calendar year</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .

Services include:

- An initial court-ordered exam for a *covered dependent* age 18 and under;
- Those for a medical and/or mental or substance abuse related diagnosis, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), leading to significant disruption of function in *your* life situation and has a recognized effective treatment.

The *Plan Administrator* or its designee determines when there is a serious or persistent mental or nervous condition that meets criteria for coverage. The *Plan Administrator* or its designee must approve any services received in *your* home. Services from a licensed chemical rehabilitation program are covered.

**Outpatient Services, Partial Hospital and Day Treatment Services.** Outpatient Services, Partial *Hospital* and *Day Treatment Services* should be prior authorized.

#### The *Plan* covers:

- Outpatient professional services for evaluation and diagnostic services, crisis intervention, therapeutic services including psychiatric services and treatment of mental and nervous conditions;

- Diagnosis and treatment of substance-related conditions including evaluations, diagnostic services, therapeutic services and psychiatric services;
- Outpatient individual and group therapy;
- Outpatient family therapy that is recommended by a designated *provider* treating a minor covered dependent child;
- Medication management; and
- *Biofeedback*.

The results of a comprehensive diagnostic assessment will be used by a mental health professional to evaluate the appropriate treatment modality and the extent of services required. These services must be provided by a licensed mental health professional.

Pre-certification is required in order to receive medication management services in the home. Medication management may be provided on an outpatient basis or in the *covered person's* home.

**Inpatient Hospital Services.** The *Plan* covers inpatient services in a *hospital* or licensed residential treatment facility and professional services. These services must be pre-certified.

The *Plan* covers a semi-private room. *Benefits* for a private room are available only when the private room is *medically necessary* for a *sickness* or *injury* or if it is the only option available at the admitted facility. If *you* choose a private room when it is not *medically necessary*, *Plan* payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

If *you* were incapacitated in a manner that prevented *you* from providing the required notice described under “*Emergency Room Services*”, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: (1) *you* are physically or mentally unable to provide the required notice; and (2) *you* are unable to provide the notice through another person.

### **Exclusions:**

- Please see the section entitled “Exclusions”.
- Counseling, studies, services or *confinements* ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator* or its designee.
- Marital counseling, relationship counseling, family counseling except as described in this *SPD*, or other similar counseling or training services.
- Treatment of compulsive gambling.
- Mental health or substance related conditions that the *Plan Administrator* or its designee determines cannot be improved with treatment, except as stated in this *SPD*.
- Mental retardation or mental conditions that, according to generally accepted professional standards, are not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.
- Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
- Early behavioral interventions for children including but not limited to Lovaas therapy, applied behavior analysis, discrete trial training, and intensive intervention programs.
- Methadone or Cyclazocine for substance-related treatment.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Home based mental or behavioral health services.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**P. Office Visits and Urgent Care Center Visits**

<i>Sickness or Injury</i>	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Implantable and insertable devices for birth control.	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
Injectable drugs that are not <i>specialty drugs</i> , excluding insulin.	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
<b>Preventive Health Care Services</b>	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.
<ul style="list-style-type: none"> <li>• Services for routine screening procedures for cancer including: mammograms, pap smears, bone density, prostate specific antigen (PSA), and colonoscopies.</li> <li>• Routine eye examinations limited to one exam per <i>covered person</i> per <i>calendar year</i>.</li> <li>• Routine hearing examinations limited to one exam per <i>covered person</i> per <i>calendar year</i>.</li> <li>• Prenatal care.</li> </ul>		
<b>Urgent Care Center</b>	100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .

Office visits and *urgent care center* visits related to diagnosis, care or treatment of a condition, *sickness* or *injury*:

- Laboratory tests, pathology and radiology.
- Allergy injections.
- Treatment of diagnosed Lyme Disease.
- Contact lenses prescribed as *medically necessary* are covered if not a part of a surgical procedure. The lenses and fitting are *eligible charges* under the Durable Medical Equipment (DME) *benefit*. *Covered persons* must pay for lens replacement.
- Surgical service performed during an office visit, including elective sterilization.
- Oral surgery is covered for: (a) treatment of oral neoplasm, and non-dental cysts; (b) fracture of the jaws; and (c) trauma to the mouth and jaws.
- Treatment of cleft lip and cleft palate for a *covered dependent* child to age 18, including orthodontic treatment and oral surgery directly related to the cleft. Dental services required for the treatment of cleft lip or cleft palate are covered. If a *covered dependent* child is also covered under a dental plan that includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.
- Treatment of confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD) if *your* primary diagnosis is TMD. Dental services required to directly treat TMD or CMD are eligible. TMD splints are *eligible charges* under the Durable Medical Equipment (DME) *benefit*, if *your* primary diagnosis is TMD.

- Port wine stain treatment to lighten or remove the coloration through age 15.
- Diabetic outpatient self-management training and *educational* services.
- An *emergency* examination of a child ordered by judicial authorities.
- Implantable drug delivery devices for birth control.
- Injectable drug delivery devices for birth control, including associated *physician* charges.
- Intrauterine devices (IUD's) for birth control, including associated *physician* charges.
- Services provided by an audiologist.
- *Biofeedback*.

Office visits related to *preventive health care* services when submitted by the *provider* with a routine *preventive health care* exam diagnosis:

- *Preventive health care* exams and periodic health supervision services provided during an office visit when there is no existing condition or complaint about *your* health.
- Well-baby and child health supervision services to age 6 including pediatric *preventive health care* services, routine immunizations, developmental assessments and laboratory services.
- Routine screening procedures for cancer, including mammograms, pap smears and prostate specific antigen (PSA).
- Lead poisoning screenings to age 6.
- Laboratory tests, pathology and radiology.
- Routine eye screening and exam, limited to one exam per *covered person* per *calendar year*.
- Routine hearing screening and exam, limited to one exam per *covered person* per *calendar year*.
- Immunizations based on community standards, including flu shots.
- Prenatal care and postnatal care.
- Health education obtained through a provider or facility. Coverage does not include a wellness center or health club.

### **Exclusions:**

- Please see the section entitled "Exclusions".
- Services, seminars, or programs that are primarily *educational* in nature.
- Health education.
- Smoking cessation programs.
- Nutritional counseling, except when provided during a *confinement*, or for the diagnosis and treatment of diabetes or an eating disorder.
- Recreational therapy.
- Professional sign language and foreign language interpreter services in a *provider's* office.
- Exams, other evaluations, and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section.
- Charges for duplicating and obtaining medical records from *non-participating providers*, unless requested by the *Plan Administrator* or its designee.
- Genetic testing and associated services when done as a screening test to predict whether *you* may be a carrier of a specific *sickness* when *you* are not diagnosed with a specific *sickness* by a *physician* or *you* are not at high risk for the specific *sickness* as confirmed by a *physician*. This exclusion does not apply to *medically necessary* prenatal fetal or maternal genetic testing (e.g. amniocentesis, chorionic villous sampling) when done as a part of the care of a *covered person's* pregnancy.
- Homeopathic medicine; acupuncture, except for chronic pain programs; hypnosis; and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Treatment of cleft lip and cleft palate for a *covered person* age 18 and over.
- Vision therapy/Orthoptics.
- School physicals.
- Audiologist services not provided in an office setting.
- All weight loss programs, including, but not limited to, consultations, laboratory services, testing, nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

<i>Benefits</i>	<i>Designated Transplant Network</i>
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**Q. Organ And Bone  
Marrow Transplant  
Services**

See “Office Visits” and “Hospital Services”.

The *Plan* covers eligible *transplant services* that are pre-certified and determined by the *Plan Administrator* or its designee to be *medically necessary* and not *investigative*. If the transplant is *medically necessary*, but is part of a clinical trial, then *benefits* are available only for the *transplant services* that are not part of the clinical trial and therefore not *investigative*. *Transplant services* must be received at a *designated transplant network provider*.

Coverage for organ transplants, bone marrow transplants and bone marrow rescue services is subject to periodic review. The *Plan Administrator* or its designee evaluates *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and it results in specific guidelines about *benefits* for *transplant services*. You may call the *TPA* at the telephone number listed inside the front cover for information about these guidelines.

*Benefits* may be available for the following transplants when the transplant meets the definition of a *covered service* and is not *investigative*:

- Bone marrow transplants and peripheral stem cell transplants with or without high dose chemotherapy.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Pancreas transplants.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant related treatment provided shall be subject to and in accordance with the provisions, limitations, and other terms of this *SPD*.

Medical and *hospital* expenses of the donor are covered only when the recipient is a *covered person* and the transplant has been authorized in advance by the *Plan Administrator* or its designee. Treatment of medical complications that may occur to the donor are not covered.

**Exclusions:**

- Please see the section entitled “Exclusions”.
- Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures for a condition that is *investigative*.
- Supplies, drugs and aftercare for or related to non-human organ implants.
- Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by the *Plan Administrator* or its designee.
- Services, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
- Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**R. Physical Therapy,  
Occupational Therapy  
And Speech Therapy**

See “Office Visits” and “Hospital Services”.	See “Office Visits” and “Hospital Services”.
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The *Plan* covers outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative therapy* rendered to treat a medical condition, *sickness* or *injury*. The *Plan* also covers outpatient PT, OT and ST *habilitative therapy* for medically diagnosed conditions that have significantly limited the successful initiation of normal motor or speech development. Therapy must be ordered by a *physician, physician’s assistant*, or certified nurse practitioner, and the therapy must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist, or speech therapist for appropriate services within their scope of practice. Coverage is limited to *rehabilitative therapy* or *habilitative therapy* that demonstrates measurable functional improvement within a reasonable period of time.

**Exclusions:**

- Please see the section entitled “Exclusions”.
- *Custodial care* or maintenance care.
- Recreational, *educational*, or self-help therapy (such as, but not limited to, health club memberships or exercise equipment).
- Therapy provided in *your* home for convenience.
- Therapy for the treatment of articulation or phonological disorders, speech disorders.
- Therapy for treatment of stuttering.
- Therapy for conditions that are self-correcting.
- Services which do not demonstrate measurable and sustainable improvement within 2 weeks to 3 months, depending on the physical and mental capacities of the individual.
- Voice training and voice therapy.
- Secretin infusion therapy.
- *Investigative* therapies for the treatment of autism, such as secretin infusion therapy.
- Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
- Group therapy for PT, OT and ST.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**S. Prescription Drug Services**

Coverage includes *prescription drugs* dispensed at a pharmacy.

<ul style="list-style-type: none"> <li>• up to a 34-day supply or 100 units, whichever is greater;</li> <li>• up to a 34-day supply for one type of insulin;</li> <li>• oral contraceptives for a 3-month supply;</li> <li>• diaphragms;</li> <li>• prenatal vitamins for a 34-day supply;</li> <li>• special dietary treatment for phenylketonuria (PKU), enteral feedings and total parenteral nutrition;</li> <li>• blood factors;</li> <li>• drugs for treatment of infertility, limited to 6 cycles per lifetime;</li> <li>• drugs for treatment of impotency, limited to 10 pills per covered person per month;</li> <li>• Zyban;</li> <li>• acne drugs for <i>covered persons</i> under age 25 or age 25 and over if there is a diagnosis of adult acne.</li> </ul>	<p><b>Generic drugs:</b> 100% of <i>eligible charges</i> after \$5 <i>copayment</i> per prescription unit or refill.</p> <p><b>Brand-name drugs:</b> 100% of <i>eligible charges</i> after \$10 <i>copayment</i> per prescription unit or refill.</p> <p><i>Deductible</i> does not apply.</p>	Not covered.
<ul style="list-style-type: none"> <li>• diabetic supplies</li> </ul>	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	80% of <i>eligible charges</i> after the <i>deductible</i> .
Mail order drugs for up to a 90-day supply	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not applicable.
<ul style="list-style-type: none"> <li>• <i>Specialty drugs</i> (excluding insulin) <ul style="list-style-type: none"> <li>a. Up to a 34 day supply;</li> <li>b. <i>Specialty drugs</i> may be oral or injectable;</li> <li>c. Must be purchased through a specialty pharmacy.</li> <li>d. A list of these <i>specialty drugs</i> may be obtained on the <i>Plan's</i> website or by calling Customer Service.</li> <li>e. The list of <i>specialty drugs</i> may be revised from time to time without notice.</li> </ul> </li> <li>• Injectable drugs that are not <i>specialty drugs</i>, excluding insulin.</li> </ul>	<p><b>Generic drugs:</b> 100% of <i>eligible charges</i> after \$5 <i>copayment</i> per prescription unit or refill.</p> <p><b>Brand-name drugs:</b> 100% of <i>eligible charges</i> after \$10 <i>copayment</i> per prescription unit or refill.</p> <p><i>Deductible</i> does not apply.</p>	Not covered.

If *you* request a brand name drug when an equivalent generic drug is available, or if *your physician* writes a prescription for a brand name drug and writes “dispense as written” (“DAW”), *you* are required to pay the brand name *copayment*.

*Compounded drugs* will be covered provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the compounded product will be considered for coverage after documented failure of the commercially prepared product(s). A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable *benefit* level will be applied. *Compounded drugs* containing any product that is excluded by the *Plan* will not be covered including dosages and route of administration that have not been approved by the FDA.

*Compounded drugs* will be covered according to the *covered person's* pharmacy network *benefits*. If a *non-participating provider* pharmacy is used to obtain the compounded prescription, the *non-participating provider benefits* will apply without exception.

**Pre-authorization.** Certain *prescription drugs* may require pre-authorization before *you* can have *your* prescription filled at the pharmacy. For information, *you* may call the *TPA* at the phone number listed on the inside front cover of this *SPD*. These *prescription drugs* include, but are not limited to:

- *Specialty drugs*.
- Topical and oral - acne medications for *covered persons* age 25 and over.
- Weight loss drugs, only when *medically necessary* to treat obesity as determined by the *Plan Administrator* or its designee.

### **Exclusions:**

- Please see the section entitled “Exclusions”.
- Replacement of a *prescription drug* due to loss, damage, or theft.
- Drugs available over-the-counter (OTC) that by applicable law do not require a prescription.
- OTC home testing products; except as provided in this *SPD*.
- Drugs not approved by the FDA.
- Take home drugs when dispensed by a *physician*.
- Weight loss drugs, except when *medically necessary* to treat obesity.
- *Prescription drugs* and *OTC* drugs for smoking cessation other than Zyban.
- Enteral feedings and other oral nutritional and electrolyte substances, except to treat PKU.
- Drugs used for *cosmetic* purposes.
- Unit dose packaging per request of the *covered person*.
- Homeopathic medicine, including dietary supplements.
- More than a 1-month supply of drugs dispensed at a time for controlled drugs.
- More than 6 cycles of *prescription drugs* for the treatment of infertility per lifetime.
- *Prescription drugs* to treat sexual dysfunction, except as provided in the “*Prescription Drug Services*” schedule.
- *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Growth hormone therapy.
- Topical and oral acne medications for *covered persons* age 25 and over, unless prior authorized for adult acne.
- Certain *combination drugs* and other drugs, regardless of status will not be covered according to the *Plan's* pharmacy policy titled “Cost Benefit Program.” Contact Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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## **T. Reconstructive Surgery**

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100% of <i>eligible charges</i> after the <i>deductible</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .
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The *Plan* covers *reconstructive* surgery due to *sickness*, accident or congenital anomaly. *Eligible charges* include eligible *hospital, physician, laboratory, pathology, radiology* and facility charges. Contact Customer Service to determine if a specific procedure is covered.

*Reconstructive* surgery following a mastectomy includes the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of mastectomy, including lymphedemas.

### **Exclusions:**

- Please see the section entitled “Exclusions”.
- Services and/or drugs to treat conditions that are *cosmetic* in nature.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i>
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**U. Skilled Nursing Facility Services**

Coverage is limited to a maximum of 30 days per *covered person* per *confinement*. Successive *confinements* are considered one *confinement* if due to the same *sickness or injury* and separated by less than 180 days.

100% of *eligible charges* after the *deductible*.

80% of *eligible charges* after the *deductible*.

The *Plan* covers the eligible *skilled nursing facility* services for post-acute treatment and *rehabilitative care* of a *sickness or injury*. These services must be directed by a *physician* and authorized in advance by the *Plan Administrator* or its designee. Please follow the pre-certification procedure described in Section VI., *Benefit Schedule*, for the procedure *you* must follow.

*Skilled nursing facility* services include room and board, daily skilled nursing and related ancillary services. The *Plan Administrator* or its designee determines when care no longer meets criteria for coverage.

The *Plan* covers a semi-private room. *Benefits* for a private room are available only when the private room is *medically necessary* for a *sickness or injury* or if it is the only option available at the admitted facility. If *you* choose a private room when it is not *medically necessary*, *Plan* payment toward the cost of the room shall be based on the average semi-private room rate in that facility. Only services that qualify as reimbursable under Medicare are *eligible charges*.

**Exclusions:**

- Please see the section entitled “Exclusions”.
- Hospitalization, transportation, supplies, or medical services, including *physicians’* services furnished by the United States Government or by an institution operated by the United States Government, unless payment is required in accordance with applicable law.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Respite or *custodial care*.
- Educational care.

## VII. Exclusions

**Many exclusions are interrelated so please read this entire section. The *Plan* will not cover charges *incurred* for any of the following services:**

1. Services or supplies that the *Plan Administrator* or its designee determines are not *medically necessary*.
2. Services or supplies received before coverage under this *Plan* begins or after *your* coverage under this *Plan* ends.
3. *Investigative* procedures, clinical trials, and associated expenses.
4. Services or supplies not directly related to *your* care.
5. Services or supplies ordered or rendered by *providers* or para-professionals unlicensed by the appropriate state regulatory agency.
6. Services, drugs, or supplies not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
7. Charges for services determined to be duplicate services by the *Plan Administrator* or its designee.
8. Services prohibited by law or regulation, or illegal under applicable laws.
9. Charges for services that are eligible for payment under any insurance policy, including auto insurance, or under a Workers' Compensation law, employer liability law or any similar law.
10. Services that are paid or payable under Medicare Part B but only to the extent *you* are eligible to be covered under Medicare Part B and *you* and/or this *Plan* are not subject to Medicare secondary rules.
11. Charges *incurred* outside the United States, if the *covered person* traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies.
12. Eyeglasses, frames and their related fittings.
13. Contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.
14. Personal comfort or convenience items.
15. Any service or supply provided by a relative (i.e., a spouse, or a parent, brother, sister, or child of the *covered employee* or of the *covered employee's* spouse) or anyone who customarily lives in the *covered employee's* household.
16. Services provided by certified surgical technicians, certified surgical assistants, first surgical assistants, or orthopedic technicians.
17. Services provided by massage therapists, doulas, and personal trainers.
18. Sexual devices, services, or supplies for the treatment of sexual dysfunction, except as otherwise covered in this *SPD*.
19. Charges for medical services that are paid or payable under any auto insurance policy, which covers the *covered person*, or for which the *covered person* is required by law to enroll.
20. Procedures that are always *cosmetic*, or for convenience or comfort reasons, as listed on the *Plan's* Cosmetic Procedures Policy.
21. Orthognathic surgery.

22. Massage therapy.
23. Telephone consultations.
24. Electronic mail consultations.
25. Alternative therapies such as aromatherapy and reflexology.
26. *Vocational rehabilitation.*
27. Acupuncture, except for chronic pain programs.
28. Charges billed by *providers* that are not in compliance with generally accepted guidelines established by the Centers for Medicare & Medicaid Services (CMS) and/or the *TPA*'s policies.
29. *Sickness* or *injury* that results from:
  - Engaging in an illegal act or the attempt to engage in a felony act, whether or not the individual is formally charged or convicted of such an act. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition, such as alcoholism.
  - Voluntary participation in a riot, insurrection or civil disobedience.
  - War or any act of war. "War" means declared or undeclared war and includes acts of terrorism.
30. *Sickness* or *injury* that results from self-inflicted *injury* (other than suicide or attempted suicide). This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition, such as depression.
31. Expenses *incurred* for which *you* are entitled to receive *benefits* under *your* previous medical or dental plan.
32. Services that are not provided by, authorized by, or prescribed by a qualified practitioner or qualified treatment center.

**The following exclusions are repeated from Section VI., "Benefit Schedule:"**

**\*For ease of reference, some exclusions may contain headings for categories of benefit services and supplies. Please note that, exclusions listed under all categories of benefit services and supplies shall apply to all services and supplies, regardless of the heading under which they are listed.**

33. Ambulance Services:
  - See all exclusions.\*
  - Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
34. Chiropractic Services:
  - See all exclusions.\*
  - Routine maintenance chiropractic care.
  - Acupuncture, except for chronic pain programs.
  - Blood, urine or hair analysis related to chiropractic services.
  - Ultrasound, MRI, EMG, waveform, and nuclear medicine diagnostic studies related to chiropractic services.
  - Manipulation under anesthesia related to chiropractic services.
  - Homeopathic/holistic services related to chiropractic services.
35. Dental Services:
  - See all exclusions.\*
  - Dental services covered under *your* dental plan, except as stated in the Dental Services provision.
  - Preventive dental procedures.
  - Dental services, orthodontia and all associated expenses, except as stated in this section.
  - Services for cracked or broken teeth that result from biting, chewing, disease or decay.
  - Dental implants.

- Dental services related to periodontal disease.
36. Durable Medical Equipment (DME), Services and Prosthetics:
- See all exclusions.\*
  - Any durable medical equipment or supplies not listed as eligible on the *Plan's* durable medical list, or as determined by the *Plan Administrator* or its designee.
  - Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
  - Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
  - Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
  - Replacement or repair of items when: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
  - Duplicate or similar items.
  - Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation.
  - Hearing aids, devices to improve hearing and related fittings, except for children under age five and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
  - Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
  - Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
  - Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts and car carrier.
  - Over-the-counter orthotics and appliances.
  - Other equipment and supplies, and oral nutritional and electrolyte substances that the *Plan Administrator* or its designee determines are not eligible for coverage, except for the treatment of PKU.
  - Charges for sales tax, mailing or delivery.
  - Wigs.
  - Durable medical equipment, orthotics, and prosthetics that are necessary for activities beyond activities of daily living (ADL's).
  - Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
37. *Emergency Services*:
- See all exclusions.\*
  - Non-*emergency* services received in an *emergency* room.
38. Home Health Services:
- See all exclusions.\*
  - Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
  - Services provided as a substitute for a primary caregiver in the home.
  - Services that can be performed by a non-medical person or self-administered.
  - Home health aides, unless determined to be *medically necessary* by the *Plan Administrator* or its designee.
  - Services provided in *your* home for convenience.
  - Services provided in *your* home due to lack of transportation.
  - *Custodial care*.
  - Services at any site other than *your* home.
  - Recreational therapy.
  - Services rendered by *providers* unlicensed or not certified by the appropriate state regulatory agency.
39. Hospice Care:
- See all exclusions.\*
  - Services provided by *your* family or a person who shares *your* legal residence.
  - Respite or rest care, except as specifically described in this section.
40. *Hospital Services*:
- See all exclusions.\*
  - Travel, transportation, other than ambulance transportation, or living expenses.

- Hospitalization, transportation, supplies, or medical services, including *physicians'* services furnished by the United States Government or by an institution operated by the United States Government, unless payment is required in accordance with applicable law.
- Nutritional counseling, except when provided during a *confinement* or for the diagnosis and treatment of diabetes, or an eating disorder.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
- Services and/or drugs to treat conditions that are *cosmetic* in nature.
- Orthoptics.
- Refractive surgery (e.g. lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Services and/or surgery and associated expenses for gender reassignment.
- Genetic testing and associated services when done as a screening test to predict whether *you* may be a carrier of a specific *sickness* when *you* are not diagnosed with the specific *sickness* by a *physician* or *you* are not at high risk for the specific *sickness* as confirmed by a *physician*. This exclusion does not apply to *medically necessary* prenatal fetal or maternal genetic testing (e.g. amniocentesis, chorionic villous sampling) when done as a part of the care of a *covered person's* pregnancy.
- Homeopathic medicine, acupuncture except for chronic pain programs, hypnosis, and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Autopsies, unless requested by the *Plan Administrator* or its designee.
- Cochlear implants, except for children under age five and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
- All weight loss programs, including, but not limited to, consultations, laboratory services, testing, nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

#### 41. Infertility Services:

- See all exclusions.\*
- Charges for treatment in excess of \$10,000 (not including *prescription drugs*.)
- Artificially assisted technology.
- In vitro fertilization.
- Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
- Surrogate pregnancy.
- Sperm banking.
- Embryo and egg storage.
- Reversal of voluntary sterilization.
- Donor sperm.
- More than 6 cycles for AI and/or IUI and/or *prescription drugs* unless a pregnancy is attained and the *benefit* is renewed.

#### 42. Mental Health and Substance Related Services:

- See all exclusions.\*
- Counseling, studies, services or *confinements* ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator* or its designee.
- Marital counseling, relationship counseling, family counseling except as described in this *SPD*, or other similar counseling or training services.
- Treatment of compulsive gambling.
- Mental health or substance related conditions that the *Plan Administrator* or its designee determines cannot be improved with treatment, except as stated in this *SPD*.
- Mental retardation or mental conditions that, according to generally accepted professional standards, are not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.
- Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g., detoxification centers).
- Early behavioral interventions for children including but not limited to Lovaas therapy, applied behavior analysis, discrete trial training, and intensive intervention programs.
- Methadone or Cyclazocine for substance-related treatment.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Home based mental or behavioral health services.

43. Office Visits and *Urgent Care Center* Visits:

- See all exclusions.\*
- Services, seminars, or programs that are primarily *educational* in nature.
- Health education.
- Smoking cessation programs.
- Nutritional counseling, except when provided during a *confinement*, or for the diagnosis and treatment of diabetes or an eating disorder.
- Recreational therapy.
- Professional sign language and foreign language interpreter services in a *provider's* office.
- Exams, other evaluations, and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section.
- Charges for duplicating and obtaining medical records from *non-participating providers*, unless requested by the *Plan Administrator* or its designee.
- Genetic testing and associated services when done as a screening test to predict whether *you* may be a carrier of a specific *sickness* when *you* are not diagnosed with a specific *sickness* by a *physician* or *you* are not at high risk for the specific *sickness* as confirmed by a *physician*. This exclusion does not apply to *medically necessary* prenatal fetal or maternal genetic testing (e.g. amniocentesis, chorionic villous sampling) when done as a part of the care of a *covered person's* pregnancy.
- Homeopathic medicine; acupuncture, except for chronic pain programs; hypnosis; and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Treatment of cleft lip and cleft palate for a *covered person* age 18 and over.
- Vision therapy/Orthoptics.
- School physicals.
- Audiologist services not provided in an office setting.
- All weight loss programs, including, but not limited to, consultations, laboratory services, testing, nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

44. Organ and Bone Marrow *Transplant Services*:

- See all exclusions.\*
- Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures for a condition that is *investigative*.
- Supplies, drugs and aftercare for or related to non-human organ implants.
- Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by the *Plan Administrator* or its designee.
- Services, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
- Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood.

45. Physical Therapy, Occupational Therapy and Speech Therapy:

- See all exclusions.\*
- *Custodial care* or maintenance care.
- Recreational, *educational*, or self-help therapy (such as, but not limited to, health club memberships or exercise equipment).
- Therapy provided in *your* home for convenience.
- Therapy for the treatment of articulation or phonological disorders.
- Therapy for treatment of stuttering.
- Therapy for conditions that are self-correcting.
- Services which do not demonstrate measurable and sustainable improvement within 2 weeks to 3 months, depending on the physical and mental capacities of the individual.
- Voice training and voice therapy.
- Secretin infusion therapy.

- *Investigative* therapies for the treatment of autism, such as secretin infusion therapy.
- Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
- Group therapy for PT, OT and ST.

46. *Prescription Drug Services*

- See all exclusions.\*
- Replacement of a *prescription drug* due to loss, damage, or theft.
- Drugs available over-the-counter (OTC) that by applicable law do not require a prescription.
- OTC home testing products; except as provided in this *SPD*.
- Drugs not approved by the FDA.
- Take home drugs when dispensed by a *physician*.
- Weight loss drugs, except when *medically necessary* to treat obesity.
- *Prescription drugs* and *OTC* drugs for smoking cessation other than Zyban.
- Enteral feedings and other oral nutritional and electrolyte substances, except to treat PKU.
- Drugs used for *cosmetic* purposes.
- Unit dose packaging per request of the *covered person*.
- Homeopathic medicine, including dietary supplements.
- More than a 1-month supply of drugs dispensed at a time for controlled drugs.
- More than 6 cycles of *prescription drugs* for the treatment of infertility per lifetime.
- *Prescription drugs* to treat sexual dysfunction, except as provided in the “*Prescription Drug Services*” schedule.
- *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Growth hormone therapy.
- Topical and oral acne medications for *covered persons* age 25 and over, unless prior authorized for adult acne.
- Certain *combination drugs* and other drugs, regardless of status will not be covered according to the *Plan's* pharmacy policy titled “Cost Benefit Program.” Contact Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.

47. *Reconstructive Surgery:*

- See all exclusions.\*
- Services and/or drugs to treat conditions that are *cosmetic* in nature.

48. *Skilled Nursing Facility Care:*

- See all exclusions.\*
- Hospitalization, transportation, supplies, or medical services, including *physicians' services* furnished by the United States Government or by an institution operated by the United States Government, unless payment is required in accordance with applicable law.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Respite or *custodial care*.
- Educational care.

## VIII. Ending *Your Coverage*

*Your coverage* under the both the HD Component and the HRA Component of the *Plan*, will terminate on the earliest of the following dates:

- The date the *Plan* is terminated;
- The end of the month in which the *covered employee* retires; provided, however, that a *covered employee* who retires and is an *eligible retiree* may elect to enroll in the HD Component;
- The last day of the month in which *your* eligibility under the *Plan* ends;
- The end of the month in which *your* written request to cancel coverage is received; unless the *covered employee's* premium payments are paid on a pre-tax basis, as pre-tax premium payments can only cease when certain change in status events occur;
- When *contribution* for coverage under the *Plan* is not made. Termination will be retroactive to the last day for which *contribution* has been received;

- The date *you* have performed an act or practice that constitutes fraud or made an intentional misrepresentation or material fact under the terms of the *Plan*; or
- The end of the month following a layoff.

*Your* coverage under the HRA Component will terminate on the earliest of the preceding dates and the date as of which the HRA Component is terminated.

A *covered dependent* child's coverage will terminate the end of the month in which the child is no longer eligible as a *covered dependent*. If *your covered dependent* child is handicapped, coverage will end when the *covered dependent* child marries or is no longer handicapped.

## IX. Leaves of Absence

### Family and Medical Leave Act (FMLA)

If *you* are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date *you* notify the Employer that *you* do not intend to return to work. *You* are responsible for all required *contributions*.

If *you* do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that *you* elect to continue under that provision. If the *covered employee* returns to work immediately following his or her approved FMLA leave, no *waiting periods* or pre-existing condition limitations, if applicable, will apply.

### The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

**Continuation of Benefits.** *Covered employees* who are absent due to service in the uniformed services and/or their *covered dependents* may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

**Eligibility.** A *covered employee* is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

*Covered dependents* who have coverage under the *Plan* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following his or her leave under USERRA, no *waiting periods* or pre-existing condition limitations, if applicable, will apply.

**Premium Payment.** If continuation of *Plan* coverage is elected under USERRA, the *covered employee* or *covered dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the Employer.

**Duration of Coverage.** Elected continuation coverage under USERRA will continue until the earlier of:

1. 24 months, beginning the first day of absence from employment due to service in the uniformed services;
2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;
3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or
4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." *Covered employees* should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

**Return to Work Requirements.** Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period.
2. 31 to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.
3. 181 days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.
4. Service-connected *injury* or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

## **X. COBRA Continuation Coverage**

The *covered employee*, his or her covered spouse and covered dependent children may continue coverage under the *Plan*, which consists of both the HD Component and the HRA Component, when a qualifying event occurs. *You* may elect COBRA for both components or *you* may elect COBRA for just the HD Component or just the HRA Component. *You* may elect COBRA for yourself regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children.

1. In certain cases, the *covered employee* may continue his or her coverage and may also continue coverage for his or her covered spouse and covered dependent children when coverage would normally end;
2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end;
3. Coverage will be the same as that for other similar *covered persons*; and
4. Continuation coverage under this *Plan* ends when this *Plan* terminates or as explained in detail on the following Continuation Chart. The *covered employee*, his or her covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. *You* should contact the Employer for details about other continuation coverage.

An *eligible retiree* who waives or does not elect COBRA coverage, and who elects to participate in the Limited HRA Option, has no further COBRA rights with respect to the Limited HRA Option, when the early retiree coverage under the Limited HRA Option ends for any reason.

**For additional information about *your* rights and obligations under the *Plan* and/or federal COBRA law, *you* should contact the Employer, which is the official *Plan Administrator*.**

### **Qualifying Events**

1. Loss of coverage under this *Plan* by the *covered employee* due to one of these events:
  - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than “gross misconduct.”
  - b. Reduction in the hours of employment of the *covered employee*.
  - c. Layoff of the *covered employee*.
  - d. Leave of absence of the *covered employee*.
  - e. Early retirement of the *covered employee*.
2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
  - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than “gross misconduct.”
  - b. Reduction in the hours of employment of the *covered employee*.
  - c. Layoff of the *covered employee*.
  - d. Leave of absence of the *covered employee*.
  - e. Early retirement of the *covered employee*.
  - f. *Covered employee* becoming entitled to Medicare.
  - g. Divorce or legal separation of the *covered employee*.
  - h. Death of the *covered employee*.

3. Loss of coverage under this *Plan* by the covered dependent child due to his or her loss of “dependent child” status under this *Plan*.
4. Loss of coverage under this *Plan* due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, his or her covered spouse and covered dependent children.

### **Required Procedures**

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, or the bankruptcy of the Employer, the *Plan Administrator* will offer continuation coverage to qualified *covered persons*. *You* do not need to notify the *Plan Administrator* of these qualifying events. However, for other qualifying events including divorce or legal separation of the *covered employee* and loss of dependent child status, COBRA continuation is available only if *you* provide timely, written notice to the *Plan Administrator* as required below by the *Plan*. *You* must also provide timely, written notice to the *Plan Administrator* of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the *Plan* as stated in this section. To elect COBRA, *you* must make a timely, written election as required by the *Plan* as stated in this section.

### **What the *Plan Administrator* must do:**

1. Provide initial general COBRA notices as required by law;
2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;
3. Notify persons of the unavailability of COBRA continuation;
4. Notify the *covered person* of his or her rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered spouse and/or covered dependent children;
5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and
6. Notify the *covered person* when he or she is no longer entitled to COBRA or when his or her COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

### **What *You* must do:**

1. *You* must notify the *Plan Administrator* in writing of a divorce or legal separation within 60 calendar days after the date of the qualifying event, or the date coverage would end due to the qualifying event, whichever is later;
2. *You* must notify the *Plan Administrator* in writing of a covered dependent child ceasing to be eligible within 60 calendar days after the date of the qualifying event, or the date coverage would end due to the qualifying event, whichever is later;
3. *You* must submit *your* written notice of a qualifying event within the 60 day timeframe, as explained previously in Item #1 and #2, using the *Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* (St. Croix County) in writing and must include the following:
  - the name of the *Plan*;
  - the name and address of the *covered employee* or former *covered employee*;
  - the names and addresses of all applicable dependents;
  - the description and date of the qualifying event;
  - requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation, marriage certificate for child, student transcript showing last day of student enrollment for child etc.; and
  - the name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his or her dependent(s); or a representative acting on behalf of the employee or dependent(s).

**All written notices as described previously in 1, 2, and 3, under “What You must do”, must be sent to the Plan Administrator (St. Croix County) at the address indicated in the section of this SPD entitled “Specific Information About Your Plan”.**

If *you* do not supply all notice requirements in writing as previously described, then *you* must follow the *Plan’s* requirements and specified time period for submitting, in writing, all required information and supporting documentation.

4. To elect continuation, *you* must notify the *Plan Administrator* of *your* election in writing within 60 calendar days after the date the *covered person’s* coverage ends, or the date the *covered person* is notified of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Plan’s* approved election form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This election must be submitted to the *Plan Administrator* in writing at the address as described in this section; and
5. *You* must pay continuation premium *contributions*:
  - a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional 2% of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan’s* total cost of coverage. The continuation election form will set forth *your* continuation premium *contribution* rate(s).
  - b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person’s* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
  - c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

**What You must do to apply for COBRA extension:**

**A. Social Security Disability:**

1. If *you* are currently enrolled in COBRA continuation under this *Plan*, and it is determined that *you* are totally disabled by the Social Security Administration within the first 60 calendar days of *your* current COBRA coverage, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee’s* leave of absence, retirement, reduction in hours, layoff, or his or her termination of employment for reasons other than gross misconduct. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing of the Social Security Administration’s determination within 60 calendar days after the latest of:
  - the date of the Social Security Administration’s disability determination;
  - the date of the *covered employee’s* termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
  - the date on which *you* would lose coverage under the *Plan* as a result of the *covered employee’s* termination, reduction of hours, leave of absence, retirement, or layoff.
2. *You* must submit *your* written notice of total disability within the 60 day timeframe, as described previously in Item #1, and before the end of the 18<sup>th</sup> month of *your* initial COBRA coverage using the *Plan’s* approved disability notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted, in writing, to the *Plan Administrator* and must include the following:
  - the name of the *Plan*;
  - the name and address of the *covered employee* or former *covered employee*;
  - the names and addresses of all applicable dependents currently on COBRA;
  - the description and date of the initial qualifying event that started *your* COBRA coverage;
  - the name of the disabled *covered person*;
  - the date the *covered person* became disabled;
  - the date the Social Security Administration made its determination of disability;
  - requested copy of the Social Security Administration’s determination of disability; and

- the name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his or her dependent(s); or a representative acting on behalf of the employee or dependent(s).

If *you* do not supply all notice requirements in writing as previously described, then *you* must follow the *Plan's* requirements and specified time period for submitting, in writing, all required information and supporting documentation.

All written notices required for COBRA for a Social Security disability extension must be sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*".

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the Social Security Administration's determination, in writing, within the 60 calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in Item #1 and #2, and submitting the *Plan's* approved form; and
4. *You* must pay continuation premium *contributions*:
  - a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional 2% of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The disability notice form will set forth *your* continuation premium *contribution* rate(s).
  - b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
  - c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

**B. Second Qualifying Events for *Covered Dependents* Only:**

1. If *you* are currently enrolled in COBRA continuation under this *Plan* and the *covered employee* dies, or in the case of divorce or a legal separation of the *covered employee*, or a covered dependent child loses eligibility, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff or his/her termination of employment for reasons other than gross misconduct or resulted from a Social Security Administration disability determination. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing within 60 calendar days after the later of:
  - the date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
  - the date on which the *covered dependent(s)* would lose coverage as a result of the second qualifying event.

**Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a *covered employee* becomes entitled to Medicare.**

2. *You* must submit *your* written notice of a second qualifying event within the 60 day timeframe, as previously described in Item #1, using the *Plan's* approved second event notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* in writing and must include the following:
  - the name of the *Plan*;
  - the name and address of the *covered employee* or former *covered employee*;
  - the names and addresses of all applicable dependents currently on COBRA;
  - the description and date of the initial qualifying event that started *your* COBRA coverage;
  - the description and date of the second qualifying event;
  - requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation, death certificate, marriage certificate for child, student transcript showing last day of student enrollment, etc.; and
  - the name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his or her dependent(s); or a representative acting on behalf of the employee or dependent(s).

If *you* do not supply all notice requirements in writing as previously described, then *you* must follow the *Plan's* requirements and specified time period for submitting, in writing, all required information and supporting documentation.

All written notices required for COBRA for a second qualifying event extension must be sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*".

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the second qualifying event in writing within the 60 calendar day timeframe, by following the notification procedure as previously explained in Item #1 and #2, and submitting the *Plan's* approved form; and
4. *You* must pay continuation premium *contributions*:
  - a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional 2% of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The election form will set forth *your* continuation premium *contribution* rates.
  - b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
  - c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

**Additional Notices *You* Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability**

*You* must also provide written notice of (1) *your* other group coverage that begins after COBRA is elected under the *Plan*; (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the *Plan*; and (3) the *covered person*, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

*Your* written notice for the events previously described in this section must be submitted using the *Plan's* approved notification form within 30 calendar days of the events requiring additional notices as previously described. **The notification form can be obtained from the *Plan Administrator* and must be completed by *you* and timely submitted to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*".** In addition to providing all required information requested on the *Plan's* approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the *covered person* who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the *covered person* that became entitled to Medicare, and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled *covered person*, the date that the Social Security Administration determined that he or she was no longer disabled, and a copy of the Social Security Administration's determination.

**CONTINUATION CHART**

<b>If coverage under this <i>Plan</i> is lost because this happens...</b>	<b>Who is eligible to continue...</b>	<b>Coverage may be continued until</b> the earliest of: a) the date coverage would otherwise end under the <i>Plan</i> ; or b) the end of the month in which the earliest of the following applicable events occurs:
The <i>covered employee's</i> leave of absence, early retirement, hours were reduced, layoff, or his or her employment with the Employer ended for reasons other than gross misconduct.	<i>Covered employee</i> , covered spouse and covered dependent children	<ol style="list-style-type: none"> <li>1. 18 months after continuation coverage began.</li> <li>2. Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.</li> <li>3. Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.</li> <li>4. Coverage would otherwise end under the <i>Plan</i>.</li> </ol>
<ol style="list-style-type: none"> <li>1. Death of the <i>covered employee</i>.</li> <li>2. Divorce or legal separation from the</li> </ol>	Covered spouse and covered	<ol style="list-style-type: none"> <li>1. 36 months after continuation coverage began.</li> <li>2. 36 months after entitlement of <i>covered</i></li> </ol>

<p><i>covered employee</i>.</p> <p>3. Entitlement of the <i>covered employee</i> to Medicare within 18 months before the <i>covered employee's</i> hours were reduced or termination of employment for reasons other than gross misconduct.</p> <p><i>Covered person</i> must provide notice of such event in accordance with the <i>Plan's</i> notice procedures previously described for such events.</p>	<p>dependent children</p>	<p><i>employee</i> to Medicare but only for an event which is the <i>covered employee's</i> Medicare entitlement within 18 months before his/her hours were reduced or termination of employment.</p> <p>3. Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.</p> <p>4. Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.</p> <p>5. Coverage would otherwise end under the <i>Plan</i>.</p>
<p>Loss of eligibility by a covered dependent child.</p> <p><i>Covered person</i> must provide notice of such event in accordance with the <i>Plan's</i> notice procedures previously described for such events.</p>	<p>Covered dependent child</p>	<p>1. 36 months after continuation coverage began.</p> <p>2. Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.</p> <p>3. Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.</p> <p>4. Coverage would otherwise end under the <i>Plan</i>.</p>
<p>The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.</p>	<p>Covered retiree, covered spouse and covered dependent children</p>	<p>1. Lifetime continuation coverage for covered retiree.</p> <p>2. 36 months after death of covered retiree for covered spouse and covered dependent children.</p> <p>3. Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.</p> <p>4. Coverage would otherwise end under the <i>Plan</i>.</p>
<p>The <i>covered employee</i>, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the <i>covered employee's</i> leave of absence, early retirement, reduction in hours, layoff, or his or her termination of employment with the Employer for reasons other than gross misconduct.</p> <p>Notice of such disability must be provided by the <i>covered person</i> in accordance with the <i>Plan's</i> notice procedures previously described for COBRA extensions due to Social Security disability.</p>	<p><i>Covered employee</i>, covered spouse and covered dependent children</p>	<p>1. 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that <i>covered employee</i>, covered spouse or covered dependent child is no longer disabled.</p> <p>2. Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.</p> <p>3. Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.</p> <p>4. Coverage would otherwise end under the <i>Plan</i>.</p>

**If you are a *covered employee*, covered spouse, or covered dependent who is enrolled in continuation coverage under this *Plan* due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this *SPD* as referenced in the section which describes eligibility and enrollment will apply to you during the continuation period required by federal law as such provisions would apply to an active eligible *covered employee*. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a *covered employee* during his or her continuation period required by federal law, and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.**

If the continuation period required by federal law has been exhausted, and you are enrolled for additional continuation coverage pursuant to state law or the eligibility provisions of this plan, you may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for New Dependents Only.

### **Special Rule for Pre-Existing Conditions**

A *covered employee*, his or her covered spouse or covered dependent child who is enrolled in COBRA continuation under this *Plan* and then obtains other group coverage that excludes *benefits* for pre-existing conditions applicable to such *covered person*, may choose to remain on continuation under this *Plan* for the remainder of his or her continuation period for coverage of a pre-existing condition.

### **Special Rule for Persons Qualifying for Federal Trade Act Adjustments**

The Federal Trade Act of 2002 gives special COBRA rights to *covered employees* who terminate employment or experience a reduction of hours, and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under Federal Trade Act laws. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 calendar days (or less) and only during the six months immediately after their group health plan coverage ended.

If *you* qualify or may qualify for trade adjustment assistance under the Trade Act, contact the *Plan Administrator* for additional information. *You* must contact the *Plan Administrator* promptly after qualifying for trade adjustment assistance or *you* will lose *your* special COBRA rights.

### **Written Notices Required for COBRA Continuation**

**All notices, elections, and information required to be furnished or submitted by a *covered person*, covered spouse or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements, and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the *Plan*.**

## **XI. Subrogation and Reimbursement**

### **Subrogation**

The *Plan* and the *Plan Administrator* have the full and unrestricted right of subrogation with respect to any *sickness* or *injury* for which any *benefit* or payment is provided, or may at any time in the future be provided, under the *Plan*. The *Plan Administrator* has delegated to the *TPA* the ability to pursue this right, and the authority to redelegate such activity to other individuals or entities. That right of subrogation also extends to any coverage or rights a *covered person* has, or may have, under any insurance coverage, including, but not limited to, any uninsured or underinsured motorist coverage. The *Plan's* and the *Plan Administrator's* right of subrogation shall in all circumstances fully apply without limitation and shall not be reduced under any circumstances, even if a *covered person* is not made whole for his or her damages or losses, such as damages for pain and suffering, lost wages, etc.

The *Plan's* and the *Plan Administrator's* subrogation rights shall also not be reduced by any expenses *incurred* by any *covered person*, including, but not limited to, attorneys' fees. Any and all amounts recovered by or on behalf of a *covered person* by settlement, judgment, arbitration or by any means whatsoever shall be placed into a constructive trust subject to the *Plan's* and the *Plan Administrator's* right of subrogation or shall be paid over to the *Plan* without any reduction, regardless of how such amounts are characterized or allocated. The *Plan's* and the *Plan Administrator's* subrogation rights shall have priority over any rights or *claims* of a *covered person*, and pursuant to such right of priority, the *Plan* shall first be paid in full for its subrogation rights before any amount, regardless of how characterized or allocated, is retained by, or for, a *covered person*.

A *covered person* shall fully cooperate with the *Plan*, the *Plan Administrator*, the *TPA* and their designees in the enforcement of the *Plan's* and the *Plan Administrator's* subrogation rights, which cooperation shall include, but not be limited to, paying over to the *Plan* any and all amounts due the *Plan* and the execution of any agreements, assignments or other instruments requested by the *Plan*, the *Plan Administrator*, the *TPA* and their designees. If information and assistance are not provided to the *Plan* upon request, no *benefits* will be payable under the *Plan* with respect to costs *incurred* in connection with such *sickness* or *injury*. If the *sickness* or *injury* giving rise to subrogation involves a minor child or wrongful death of a *covered person*, this provision applies to the parents or guardian of the minor *covered person* and the personal representative of the deceased *covered person*. A *covered person* shall take no action which directly or indirectly adversely affects the *Plan's* and the *Plan Administrator's*

rights of subrogation, and any settlement entered into by or on behalf of a *covered person* shall be subject to and shall fully recognize the *Plan's* and the *Plan Administrator's* right of priority to be fully repaid for its subrogation rights from any and all amounts, regardless of how characterized or allocated, recovered in connection with such settlement before any amounts from such settlement are retained by, or for, a *covered person*.

As a condition of receiving *benefits* under this *Plan*, you agree:

- To reimburse the *Plan* for any such *benefits* paid or payable to, or on behalf of, the *covered person* when said *benefits* are recovered from any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, medical payment provision or other insurance policies or funds.
- The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive, final and binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Plan Administrator* has expressly delegated to other persons or entities one or more fiduciary responsibilities with respect to the *Plan*. The rights of subrogation and reimbursement shall bind the *covered person's* guardian(s), estate, executor, personal representative and heir(s).

### Reimbursement Rights

You agree to hold in constructive trust the proceeds of any settlement or judgment for the *Plan's* and the *Plan Administrator's* benefit under this Section. If you fail to reimburse the *Plan* out of any recovery or reimbursement received for all *benefits* paid or to be paid as a result of your *sickness* or *injury*, you will be liable for any and all expenses, whether fees or costs, associated with the *Plan's*, the *Plan Administrator's*, the *TPA's* and their designees' attempts to recover such money from you.

## XII. Coordination of Benefits

If you have other group medical coverage, **including coverage under Medicare**, *benefits* from this *Plan* are coordinated with the other coverage. This includes *benefits* you or your *dependents* are eligible to receive for the same expense from another group health plan, a health maintenance organization or no-fault auto insurance. Under coordination of benefits, the *benefits* you receive from all sources for the same eligible expense cannot be greater than the actual amount of the eligible expense. One plan pays *benefits* first, up to its *benefit* maximum. Then the other plan determines the *benefits* it will provide based on the remaining eligible expenses and the terms of the plan. The coordination of benefits provision determines which plan pays *benefits* first.

All *copayments*, except *copayments* for *prescription drugs* are included in the calculation of coordination of benefits.

When this *Plan* is determined to be primary, your *benefits* are not affected by coordination of benefits. You may submit charges not covered by this *Plan* for possible reimbursement by the secondary plan.

When this *Plan* pays as a secondary carrier, *benefits* are based on a "maintenance of benefits" approach. This *Plan* will not pay up to 100% reimbursement as a secondary carrier. The following examples illustrate how this approach works when this *Plan* is your secondary carrier.

#### EXAMPLES:

- The total claim for an *emergency* room visit is \$1,000. Your other insurance as primary payer paid \$950. This *Plan* would have paid \$950 had there been no other insurance. However, since the other insurance paid the same as what this *Plan* would have paid, no additional *Plan* payment would be made.
- The total claim for an office visit is \$100. Your office visit *copayment* is \$10 and your other insurance as primary payer paid \$90. Since you have an office visit *copayment* under this *Plan* of \$10, this *Plan* would have paid \$90 had there been no other insurance. However, since the primary insurance paid the same as what this *Plan* would have paid, no additional *Plan* payment would be made if you submit the \$10 claim for reimbursement.

#### Order Of Benefit Determination Rules:

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays

without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary. **Exception:** Group coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the employer.

A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This *Plan* will not pay more than it would have paid had it been the primary plan. This *Plan* determines its order of *benefits* by using the first of the following that applies:

1. **Group/Individual Coverage:** The order of benefits when a person is covered by both an individual plan and a group or group type plan is:
  - a. The group or group type plan covering the person is the primary plan; and
  - b. The individual plan is the secondary plan.
2. **Nondependent/Dependent:** The plan that covers the person other than a dependent, for example as an employee, subscriber, or retiree is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

**Exception:** If the person is a Medicare beneficiary and federal law makes Medicare:

- a. Secondary to the plan covering the person as a dependent; and
  - b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.
3. **Child Covered Under More Than One Plan:** The order of benefits when a child is covered by more than one plan is:
    - a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
      - If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
    - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
    - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.
  4. **Active/Inactive Employee:** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 2 can determine the order of benefits. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled 2.
  5. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
    - a. the plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan, except for pre-existing conditions under such plan, and
    - b. the continuation coverage is the secondary plan, except for pre-existing conditions excluded under the primary plan.

- c. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 2 can determine the order of benefits.

6. **Longer/Shorter Length of Coverage:** The plan that covered the person as an employee, dependent or retiree for a longer time is primary.

This *Plan* has the right to obtain or provide any information needed to administer the coordination of benefits provision. This *Plan* is not required to notify *you* or ask for *your* consent. *You* and *your dependent* must also give the *Plan* any information needed to pay benefit claims.

If another medical plan pays benefits first under the coordination of benefits rule, when this *Plan* should have paid first, this *Plan* will pay the other plan back, provided the claim was valid. The amount repaid is considered a benefit paid under this *Plan*.

If this *Plan* pays more than it should have paid under the coordination of benefits rule, this *Plan* is entitled to collect the excess amount from you or your dependent or from another source.

If *you* have medical coverage under two plans that coordinate benefits, *you* can facilitate processing of *your* claims by:

- a. Submitting the claims to *your* primary carrier first;
- b. Submitting the claims and a copy of the primary carrier's explanation of benefits together to the secondary carrier.

#### **Sharing Benefits with Medicare:**

This section describes the method of payment if Medicare pays as the primary plan.

If a *participating* or *non-participating provider* has accepted assignment of Medicare, this *Plan* determines *allowable expenses* based upon the amount of charges Medicare allows.

When this *Plan* is the secondary *Plan*, the sum of the benefit payable by this *Plan* when added to the primary plan's benefits will not exceed this *Plan's* normal liability. The *eligible expenses* under this *Plan* are determined first. The amount payable under Medicare is then subtracted from the *Plan benefits* otherwise payable. The *Plan* pays the difference of the two sums.

A *member* who is eligible for Medicare will be considered covered for *benefits* payable under Medicare Parts A and B regardless of whether the person has applied for Medicare coverage.

### **XIII. How to Submit a Bill if *You* Receive One for *Covered Services***

#### **A. Bills from *Participating Providers***

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of post-service *claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit *claims* on *your* behalf. If *you* receive an invoice or bill from *your provider* for services, simply return the bill or invoice to *your provider*, noting *your* enrollment in the *Plan*. *Your provider* will then submit the post-service *claim* under the *Plan* in accordance with the terms of its participation agreement. *Your claim* will be processed for payment according to the Employer's coverage guidelines. The *TPA* must receive *claims* within 365 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. *Claims* received after the deadline will be denied.

## **B. Bills from *Non-Participating Providers***

**Claim Submission.** *You* must submit a completed *claim* form in writing, together with an itemized bill for the services *incurred*, on the *claim* form provided and in accordance with the filing procedures for post-service *claims* outlined in the next section. The *TPA* must receive *claims* within 365 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. If the *Plan* is discontinued, the deadline for the receipt of *claims* is 180 calendar days. *Claims* received after the deadline will be denied. If *you* need *claim* forms, please contact Customer Service.

**Payment of *Claims*.** *Claims* for *benefits* will be paid promptly upon receipt of written proof of loss. *Benefits* which are payable periodically during a period of continuing loss will be paid on a periodic basis. All or any portion of any *benefits* provided by the *Plan* may be paid directly to the *provider* rendering the services. Payment will be made according to the Employer's coverage guidelines.

**NOTE:** This is a non-ERISA plan. The Employer is not required to adopt *claims* procedures that comply with ERISA. However, for ease to *claims* administration, the Employer voluntarily designed the *Plan* and *SPD* to follow *claims* procedures similar to those required for ERISA-governed plans. The Employer reserves the right to amend the *Plan* at any time, including the right to amend the *claims* procedures for the *Plan*.

## **XIV. Initial *Benefit* Determinations of Post-Service *Claims* and *Claim* Appeals Process**

### **A. Initial *Benefit* Determinations of Post-Service *Claims***

Post-service *claims* are *claims* that are filed for payment of *benefits* under the *Plan* after medical care has been received and submitted in accordance with the post-service *claim* filing procedures for the *Plan*.

**Filing Procedure for Post-Service *Claims*.** To file a post-service *claim*, *you* or *your* attending *provider* must submit an itemized bill in writing and in accordance with the procedures and within the deadlines described in the section entitled "How to Submit a Bill if *You* Receive One for *Covered Services*." To be considered a properly filed post-service *claim* under the *Plan*, *your* completed *claim* form, together with an itemized bill and the essential data elements, must be submitted in writing to Customer Service at the mailing address noted inside the cover page to this *SPD*. *Your* post-service *claim* must include at least the following essential data elements:

- The identity of the *covered person* and *provider* of services;
- The date(s) of services;
- A specific medical diagnosis; and
- Specific treatment, service or product codes for which *benefits* or payment is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling Customer Service. If *you* or *your* attending *provider* have not submitted the post-service *claim* in accordance with these filing procedures, including a failure to submit all essential data elements, *your* post-service *claim* will be treated as incorrectly filed. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives a written post-service *claim* submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* files a post-service *claim* on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such *claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three (3) business days from the *Plan Administrator* or its designee's notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry that is not made in accordance with the *Plan's claim* procedures will not be treated as a *claim* under the *Plan*.

**Initial *Benefit* Determination.** If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial *benefit* determination, it may extend the time period for the initial *benefit* determination by 15 calendar days. The *TPA* will notify *you* of the

extension within the initial 30-calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial *benefit* determination within 15 calendar days after the earlier of the *TPA*'s receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. If *you* and *your* authorized representative submit the requested information within 365 calendar days after the date services were *incurred* (except in the absence of *your* legal capacity), the *Plan Administrator* or its designee may reconsider the submitted information.

The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA*'s control.

If *your* post-service *claim* is denied, notification will be provided to *you*. This notice will explain:

- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

**Note:** Refer to the subsection entitled “*Claim Appeals Process*” for details on submission of appeals.

## **B. *Claim Appeals Process***

The steps in the appeal process for the four different types of *claims* for *benefits* are outlined below:

### **Acute Care Pre-Service *Claims***

If *your* request for pre-certification of acute care services under the *Plan* is wholly or partially denied and *you* have not received such acute care services (as previously defined), *you* or *your* authorized representative may submit an appeal in accordance with this subsection.

1. *You* or *your* authorized representative may do the following:
  - Within 180 calendar days after receiving notice that *your* pre-certification request was denied, submit *your* written, oral or electronic request for appeal to the *TPA*, which will forward *your* appeal to the *Plan Administrator* for its decision; and
  - Submit issues, comments and additional information as appropriate.
2. Within 72 hours after *your* request for appeal is received, a decision on *your* appeal will be made and communicated by the *Plan Administrator*. *You* will receive notice of the *Plan Administrator*'s decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

### **Non-Acute Care Pre-Service *Claims***

If *your* request for pre-certification of non-acute care services under the *Plan* is wholly or partially denied and *you* have not received such non-acute care services (as previously defined), *you* or *your* authorized representative may submit an appeal in accordance with this subsection.

1. *You* or *your* authorized representative may do the following:
  - Within 180 calendar days after receiving notice that *your* pre-certification request was denied, submit a written first appeal to the *TPA*; and
  - Submit issues, comments and additional information as appropriate.
2. Within 15 calendar days after *your* written first appeal is received, a decision on *your* appeal will be made and communicated by the *TPA*. *You* will receive notice of the *TPA*'s decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.
3. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may do the following:

- Submit a written second appeal request to the *TPA*, which will forward *your* appeal to the *Plan Administrator* for its decision; and
  - Submit issues, comments and additional information as appropriate.
4. Within 15 calendar days after *your* written second appeal is received, a decision on *your* appeal will be made and communicated by the *Plan Administrator*. *You* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

### **Post-Service Claims**

If *your* post-service *claim* for *benefits* under the *Plan* is wholly or partially denied, *you* or *your* authorized representative may submit an appeal in accordance with this subsection.

1. *You* or *your* authorized representative may do the following:
  - Within 180 calendar days after receiving notice that *your* post-service *claim* was denied, submit a written first appeal to the *TPA*;
  - And submit issues, comments and additional information as appropriate.
2. Within 30 calendar days after *your* written first appeal is received, a decision on *your* appeal will be made and communicated by the *TPA*. *You* will receive notice of the *TPA's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.
3. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may do the following:
  - Submit a written second appeal request to the *TPA*, which will forward *your* appeal to the *Plan Administrator* for its decision; and
  - Submit issues, comments and additional information as is appropriate.
4. Within 30 calendar days after *your* written second appeal is received, a decision on *your* appeal will be made and communicated by the *Plan Administrator*. *You* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

### **Concurrent Care Claims**

If *your* concurrent care *claim* for *benefits* under the *Plan* is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to the *TPA*. Acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as acute care pre-service *claim* appeals above. Non-acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as non-acute care pre-service *claim* appeals above.

### **Access to Relevant Documents**

Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your claim* for *benefits* under the *Plan*.

## **XV. If You Have a Complaint**

If the complaint involves issues relating to quality of health care rendered by a *participating provider*, *you* should also attempt to discuss the quality of care issues with the *provider*. *You* may also direct any questions or complaints to Customer Service. When Customer Service is contacted, the representative will assist *you* in trying to resolve the complaint with the *provider* on an informal basis. The representative will also document the complaint. If these discussions are not satisfactory, *you* may submit a written complaint to the *Plan Administrator*. However, the *Plan* is not responsible for the quality of care rendered by a *participating provider*.

## **XVI. No Guarantee of Employment or Overall Benefits**

The adoption and maintenance of this *Plan* does not guarantee or represent that the *Plan* will continue indefinitely with respect to any class of employees and shall not be deemed to be a contract of employment between the Employer and any *covered employee*. Nothing contained herein shall give any *covered employee* the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any *covered employee*, at any time, nor shall it give the Employer the right to require any *covered employee* to remain in its employ or to interfere with the *covered employee's* right to terminate his or her employment at any time not inconsistent with any applicable employment contract. Nothing in this *Plan* shall be construed to extend *benefits* for the lifetime of any *covered person* or to extend *benefits* beyond the date upon which they would otherwise end in accordance with the provisions of the *Plan* or any *benefit* description.

## **XVII. Definitions of Terms Used**

<i>Assistant Surgeon</i>	Certified physician assistant (PA-C), nurse practitioner (NP), clinical nurse <i>specialist</i> (CNS), RN first assistant, certified registered nurse first assistants (CRNFA), certified nurse midwives (CNM), or <i>physicians</i> .
<i>Bariatric Surgery</i>	Surgery related to the treatment of obesity.
<i>Benefits</i>	The health care services or supplies covered under the <i>Plan</i> as approved by the <i>Plan Administrator</i> or its designee as <i>covered services</i> , as explained in this <i>SPD</i> and any amendments.
<i>Biofeedback</i>	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
<i>Calendar Year</i>	The 12-month period beginning January 1 and ending the following December 31 for provisions based on a <i>calendar year</i> .
<i>Claim</i>	A request for <i>benefits</i> made by a <i>covered person</i> or his or her authorized representative in accordance with the procedures described in this <i>SPD</i> . It includes pre-certification requests.
<i>Coinsurance</i>	A fixed percentage of <i>eligible charges</i> that is paid by <i>you</i> and a separate fixed percentage that is paid by the <i>Plan</i> to the <i>provider</i> for <i>covered services</i> and supplies. <i>Coinsurance</i> will be based on the discounted charge negotiated between the <i>TPA</i> and <i>participating providers</i> .
<i>Combination Drug</i>	A <i>prescription drug</i> in which two or more chemical entities are combined into one commercially available dosage form.
<i>Compounded Drugs</i>	Drugs which are customized drugs prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a <i>physician's</i> specifications to meet an individual patient need.
<i>Confinement</i>	An uninterrupted stay of 24 hours or more in a <i>hospital</i> , <i>skilled nursing facility</i> , rehabilitation facility or licensed residential treatment facility.
<i>Continuous Coverage</i>	The maintenance of <i>continuous</i> and uninterrupted <i>creditable coverage</i> by an eligible employee or <i>dependent</i> . An eligible employee or <i>dependent</i> is considered to have maintained <i>continuous coverage</i> if the individual enrolls in the <i>Plan</i> and the break in <i>creditable coverage</i> is less than 63 calendar days. See <i>waiting period</i> .

<i>Contribution</i>	<p>For the HD: The payment <i>your</i> Employer requires to be paid on behalf of or for <i>covered persons</i> for the provision of <i>covered services</i>. <i>Your</i> Employer will inform <i>you</i> of <i>your</i> share of the <i>contribution</i>.</p> <p>For the HRA: The amount credited to <i>your</i> HRA Account that is available for payment of <i>eligible charges</i>. It includes the employer <i>contribution</i> for the current <i>calendar year</i> plus any carryover amount from prior <i>calendar years</i>. Other than for Continuation of Coverage the <i>covered person</i> makes no <i>contribution</i> for the HRA.</p>
<i>Copayment</i>	The fixed amount of <i>eligible charges</i> <i>you</i> must pay to the <i>provider</i> for covered health services received. The <i>copayment</i> may not exceed the charge billed for the covered health care service.
<i>Cosmetic</i>	Services, medications and procedures that improve physical appearance but do not correct or improve a physiological function, or are not <i>medically necessary</i> .
<i>Covered Dependent</i>	A <i>covered employee's</i> eligible dependent as described in the section "Eligibility, Enrollment, and <i>Effective Date</i> " who is enrolled under the <i>Plan</i> .
<i>Covered Employee</i>	<p>The person:</p> <ol style="list-style-type: none"> <li>1. On whose behalf <i>contribution</i> is paid by the Employer and the <i>covered employee</i> for the HD and by the Employer for the HRA; and</li> <li>2. Whose employment is the basis for membership; and</li> <li>3. Who is enrolled under the <i>Plan</i>.</li> </ol>
<i>Covered Person</i>	A <i>covered employee</i> or <i>covered dependent</i> .
<i>Covered Services</i>	Services that are provided by <i>your provider</i> or clinic and are covered by the <i>Plan</i> , subject to all of the terms, conditions, limitations and exclusions of the <i>Plan</i> .
<i>Creditable Coverage</i>	<p>The health benefits or health coverage provided under any of the following:</p> <ol style="list-style-type: none"> <li>1. Coverage under group health plans (whether or not provided through an insurer);</li> <li>2. Medicaid;</li> <li>3. Medicare;</li> <li>4. Public health plans;</li> <li>5. National health plans or programs; as well as,</li> <li>6. All other types of coverage set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).</li> </ol>
<i>Custodial Care</i>	Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing and feeding.
<i>Day Treatment Services</i>	Any professional or health care services at a <i>hospital</i> or licensed treatment facility for the treatment of mental and substance related conditions.
<i>Deductible</i>	The amount of <i>eligible charges</i> that each <i>covered person</i> must incur in a <i>calendar year</i> before the <i>Plan</i> will pay <i>benefits</i> .
<i>Dentist</i>	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
<i>Designated Transplant Network</i>	Any <i>hospital</i> , health care <i>provider</i> , group or association of health care <i>providers</i> that has entered into a contract with or through the <i>TPA</i> to provide organ or bone marrow transplant or stem cell support and all related services and aftercare for a <i>covered person</i> .

<i>Educational</i>	A service or supply: (1) whose primary purpose is to provide training in the activities of daily living, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (2) that is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending <i>physician</i> .
<i>Effective Date</i>	The date <i>you</i> become eligible for health care services and complete all enrollment requirements, subject to any required <i>waiting period</i> .
<i>Eligible Charges</i>	A charge for health care services and supplies, subject to all of the terms, conditions, limitations and exclusions of the <i>Plan</i> for which the <i>Plan</i> or <i>covered person</i> will pay.
<i>Emergency</i>	<p><i>Emergency</i> services provided after the sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:</p> <ol style="list-style-type: none"> <li>1. Placing the <i>covered person's</i> health in serious jeopardy;</li> <li>2. Serious impairment to bodily functions; or</li> <li>3. Serious dysfunction of any bodily organ or part.</li> </ol>
<i>Enrollment Date</i>	The date of <i>your</i> enrollment in the health benefit <i>Plan</i> or, if earlier, the first day of the <i>waiting period</i> for enrollment under this <i>Plan</i> .
<i>Habilitative Therapy</i>	Therapy provided to develop initial functional levels of movement, strength, daily activity or speech.
<i>Homebound</i>	When <i>you</i> are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute <i>homebound</i> status.
<i>Hospital</i>	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of <i>physicians</i> and with 24-hour registered nursing services. The <i>hospital</i> is not mainly a place for rest or <i>custodial care</i> , and is not a nursing home or similar facility.
<i>Incurred</i>	Services and supplies rendered to <i>you</i> . Such expenses shall be considered to have been <i>incurred</i> at the time or date the service or supply was actually purchased or provided.
<i>Injury</i>	Bodily damage other than <i>sickness</i> including all related conditions and recurrent symptoms.

## *Investigative*

As determined by the *Plan*, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The *Plan* will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure the subject of ongoing Phase I, II, or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility, or another facility studying the same drug, device, medical treatment or procedure. In addition to the above, the *Plan* must determine, on a case-by-case basis, that a drug, device or medical treatment or procedure meets the following criteria:
  - a) Reliable evidence preliminarily suggests a high probability of improved outcomes compared to standard treatment (e.g. significantly increased life expectancy or significantly improved function); and
  - b) Reliable evidence suggests conclusively that beneficial effects outweigh any harmful effects; and
  - c) If applicable, the FDA has indicated that approval is pending or likely for its proposed use; and
  - d) Reliable evidence suggests the drug, device or treatment is medically appropriate for the member.

When the *Plan* determines whether a drug, device, or medical treatment is *investigative*, reliable evidence will also mean published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocols or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure, which describes among its objectives, determinations of safety, or efficacy in comparison to conventional alternatives, or toxicity or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Reliable evidence shall mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional consensus opinions of local and national health care providers.

<i>Late Enrollee</i>	An eligible employee or dependent who enrolls under the <i>Plan</i> other than during: <ol style="list-style-type: none"> <li>1. The first period in which the individual is eligible to enroll under the <i>Plan</i>; or</li> <li>2. The special enrollment period.</li> </ol>
<i>Medically Necessary/ Medical Necessity</i>	Eligible medical and <i>hospital</i> services that the <i>Plan Administrator</i> or its designee determines are appropriate and necessary, and will use its discretion on a case-by-case basis. These services include diagnostic testing, <i>preventive health care</i> services, and other health care services that are appropriate, in terms of type, frequency, level, setting, and duration, for <i>your</i> diagnosis or condition; and the care must: <ol style="list-style-type: none"> <li>1. Be consistent with the medical standards and generally accepted practice parameters of the medical community;</li> <li>2. Help restore or maintain <i>your</i> health;</li> <li>3. Prevent deterioration of <i>your</i> condition;</li> <li>4. Prevent the reasonably likely onset of a health problem or detect a problem that has no minimal symptoms.</li> </ol>
<i>Named Fiduciary</i>	The person or organization that has the authority to control and manage the operation and administration of the <i>Plan</i> . The fiduciary has discretionary authority to determine eligibility for <i>benefits</i> or to construe the terms of the <i>Plan</i> and may delegate such discretion to other individuals or entities.
<i>Non-Participating Provider</i>	A <i>provider</i> not under contract as a <i>participating provider</i> .
<i>Out-of-Pocket Limit</i>	The maximum amount of money <i>you</i> must pay in <i>coinsurance</i> and <i>deductibles</i> before this <i>Plan</i> pays <i>your eligible charges</i> at 100%. If <i>you</i> reach <i>benefit</i> or lifetime maximums, <i>you</i> are responsible for amounts that exceed the <i>out-of-pocket limit</i> .
<i>Over-the-Counter (OTC) Drugs</i>	Those drugs that are available without a <i>physician's</i> prescription being legally required.
<i>Participating Provider</i>	A <i>provider</i> that the <i>TPA</i> has contracted with or made arrangement with to provide health services to <i>covered persons</i> .
<i>Physical Handicap</i>	A condition caused by a physical <i>injury</i> or congenital defect to one or more parts of the <i>covered person's</i> body and thereafter the <i>covered person</i> is incapable to self-sustaining employment and is dependent on the employee for a majority of financial support and maintenance.
<i>Physician</i>	A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.) or Doctor of Chiropractic (D.C.).
<i>Plan</i>	The self-insured employee welfare benefit plan, established by the <i>Plan Sponsor</i> for the benefit of <i>covered persons</i> .
<i>Plan Administrator</i>	The entity, that has the exclusive, final and binding discretionary authority to administer the <i>Plan</i> , to make factual determinations, to construe and interpret the terms of the <i>SPD, Plan</i> , and amendments (including ambiguous terms), and to interpret, review, and determine the availability or denial of <i>benefits</i> . The <i>Plan Administrator</i> may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing <i>claims</i> and performing other <i>Plan</i> -connected administrative services.

<i>Plan Sponsor</i>	The entity that establishes and maintains the <i>Plan</i> , has the authority to amend and/or terminate the <i>Plan</i> and is responsible for providing funds for the payment of <i>benefits</i> .
<i>PreferredOne</i>	<i>PreferredOne</i> Administrative Services, Inc., which is a <i>third party administrator (TPA)</i> providing administrative services to <i>your</i> Employer in connection with the operation of the <i>Plan</i> .
<i>Prescription Drug</i>	A drug approved by the Federal Drug Administration for use only as prescribed by a <i>physician</i> .
<i>Preventive Health Care</i>	Health supervision including evaluation and follow-up, immunization, early disease detection and <i>educational</i> services as ordered by a <i>provider</i> .
<i>Provider</i>	A health care professional or facility licensed, certified or otherwise qualified under state law to provide health care services.
<i>Reconstructive</i>	Surgery to restore or correct: <ol style="list-style-type: none"> <li>1. A defective body part when such defect is incidental to or follows surgery resulting from <i>injury</i>, <i>sickness</i>, or other diseases of the involved body part; or</li> <li>2. A physical defect determined by a <i>physician</i> to have been present at birth and that adversely affects <i>your</i> ability to perform routine activities of daily living; or</li> <li>3. A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the <i>Plan Administrator</i> or its designee to be <i>medically necessary</i>.</li> </ol>
<i>Rehabilitative Therapy</i>	Therapy provided to restore functional levels of movement, strength, daily activity or speech after a <i>sickness</i> or <i>injury</i> .
<i>Sickness</i>	Presence of a physical or mental illness or disease.
<i>Skilled Care</i>	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess <i>your</i> changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for <i>skilled care</i> .
<i>Skilled Nursing Facility</i>	A Medicare licensed bed or facility (including an extended care facility, <i>hospital</i> swing-bed and transitional care unit) that provides <i>skilled care</i> .
<i>Specialist</i>	<i>Providers</i> other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
<i>Specialty Drugs</i>	Injectable and non-injectable <i>prescription drugs</i> having one or more of the following key characteristics: <ol style="list-style-type: none"> <li>1. Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes;</li> <li>2. Intensive patient training and compliance assistance are required to facilitate therapeutic goals;</li> <li>3. There is limited or exclusive product availability and/or distribution; or there is specialized product handling and/or administration requirements.</li> </ol>
<i>Summary Plan Description (SPD)</i>	The document describing, among other things, the <i>benefits</i> offered under the HRA High Deductible Option of the <i>Plan</i> and <i>your</i> rights and obligations under such <i>benefit</i> option.

<i>Third Party Administrator (TPA)</i>	<i>PreferredOne</i> provides administrative services to the Employer in connection with the operation of the <i>Plan</i> , including processing of <i>claims</i> , as may be delegated to it.
<i>Transplant Services</i>	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
<i>Urgent Care Center</i>	A health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
<i>Vocational Rehabilitation</i>	Services, supplies or devices for a <i>covered person</i> designed to obtain or regain skills or abilities beyond those activities of daily living, including but not limited to, a device or an enhanced device or service requested or needed to enable the <i>covered person</i> to perform activities for an occupation.
<i>Waiting Period</i>	The period of time that an individual must wait before being eligible for coverage under the <i>Plan</i> . A <i>waiting period</i> will not: (1) apply towards a period of <i>creditable coverage</i> ; or (2) be used in determining a break in <i>continuous</i> and <i>creditable coverage</i> .
<i>You/Your</i>	Refers to <i>covered employee</i> , <i>covered dependent</i> or <i>covered person</i> .