

**Clark  
County**

# Employee Welfare Benefit Plan

Plan Document and  
Summary Plan Description

Restated: January 1, 2015

Third-party Administrator:

**SecurityHealth Plan**<sup>SM</sup>

**Security Administrative Services**

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## **GENERAL PLAN INFORMATION**

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### **What is the purpose of the Plan?**

The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The Plan is not a contract of employment between you and your participating employer and does not give you the right to be retained in the service of your participating employer.

The *Plan Administrator* has determined that this *Plan* does not have grandfathered status as described in The Patient Protection and Affordable Care Act.

The Plan is an ERISA exempt plan and is subject to applicable Wisconsin state law for self-funded county plans.

### **Participant Contribution**

A Participant Contribution is the amount an employee is required to pay in order to participate in the Plan. Any required premium for coverage will be automatically taken pre-taxed unless the participant notifies the Plan Sponsor that they elect to have the deduction after taxes. Contact your employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage (COBRA)" will receive a separate notice which will indicate the cost to participate in the Plan.

The purpose of this summary plan description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The summary plan description is maintained by the Plan Administrator and may be inspected at any time during normal working hours by any covered person.

### **Mental Health Parity**

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

## **GENERAL PLAN ADMINISTRATION (CONTINUED)**

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### **General Plan Information You Should Know**

**Name of Plan:** Clark County Employee Welfare Benefit Plan

**Plan Sponsor:** Clark County Insurance Claims  
517 Court Street Room 302  
Neillsville, WI 54456  
715-743-5296

**Plan Administrator:  
(Named Fiduciary)** Clark County  
517 Court Street Room 302  
Neillsville, WI 54456  
715-743-5296

**Plan Sponsor ID No. (EIN):** 39-6005679

**Plan year:** January 1 through December 31

**Plan Number:** 501

**Plan Type:** Medical  
Prescription drug

**Third Party Administrator:** Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
(800) 570-8760

**Participating Employers:** Clark County

**Agent for Service of Process:** Clark County  
517 Court Street Room 302  
Neillsville, WI 54456  
715-743-5296

The Plan shall take effect for each participating employer on the effective date shown on the cover, unless a different date is set forth above.

The Plan is a legal entity. Clark County Employee Welfare Benefit Plan is a separate legal entity from Clark County. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

The *Plan Administrator* has determined that this *Plan* does not have grandfathered status as described in The Patient Protection and Affordable Care Act.

## **ELIGIBILITY FOR PARTICIPATION**

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### **Am I eligible to participate in the Plan?**

All full-time and part-time employees actively at work and working at least 80 hours per month on a regular basis for the employer are eligible for coverage under the Plan. Members of the Board of Supervisors are also eligible for coverage under the Plan as long as they continue to be re-elected to the Board. Members of the Board of Supervisors who are at least age 55 and who have been a member of the Board of Supervisors for at least eight years may remain eligible for coverage under the Plan even if they are not re-elected to the Board. Temporary employees, seasonal employees, leased employees (even if determined to be common-law employees) and retired employees not meeting the requirements specified in the "Retired Employee Coverage Continuation" provision are not eligible for coverage.

You are not eligible to participate if you are a temporary, leased or seasonal employee, or an independent contractor or a retired employees not meeting the requirements specified in the "Retired Employee Coverage Continuation" provision are not eligible for coverage.

You are eligible for coverage on the first of the month following 30 days of active employment. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

### **Are my dependents eligible to participate in the Plan?**

Your dependents will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;
- The date coverage for dependents first becomes available under the Plan; and
- The first date upon which you acquire a dependent.

**Please note: You must be covered under the Plan in order to cover any dependents.**

### **When will we become covered persons in the plan?**

Coverage will become effective at 12:01 A.M. (except for newborn children) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the date you or your dependents are eligible, provided you and your dependents have enrolled for coverage on a form satisfactory to the Plan Administrator within 31 days following the date of eligibility.
- Grandchild – An eligible grandchild of a covered employee may become covered under the Plan on their date of birth provided written application to elect coverage under the Plan is made within 31 days of the date of birth. If coverage is not elected in the time period specified above then the grandchild is ineligible for enrollment in the Plan, except as allowed under the special enrollment provisions of the Plan.
- Legal Guardianship - An eligible dependent child may become covered under the Plan on the date on which such child is placed in the employee's home pursuant to a court order appointing the employee as legal guardian for the child. The employee must make written application to elect coverage under the Plan within 31 days of the date on which the child is placed in the employee's home pursuant to a court order appointing the employee as legal guardian for the child. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the special enrollment provisions of the Plan.

## **ELIGIBILITY FOR PARTICIPATION (CONTINUED)**

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Children born outside of marriage may become eligible dependents of a covered employee who is the father. The employee must make written application to elect coverage under the Plan within 31 days of:

- a) The date of a court order declaring paternity; or
- b) The date the acknowledgment of paternity is filed with the Department of Health and Social Services, or its equivalent is filed with the equivalent agency in another state.

### **Transfers**

An employee transferring from another location and who is covered by another medical plan sponsored by Clark County will be eligible to elect coverage under this Plan. The employee will become effective for coverage under the Plan on the day of transfer, provided a lapse of coverage has not occurred and written application is made within 31 days of the effective date of coverage. In this instance the waiting period will not apply,

### **What if I do not enroll during my original eligibility period and later decide to apply for coverage?**

If you waived enrollment during your original eligibility period you will not be allowed to enroll in the *Plan* until the next annual open enrollment, unless you qualify for a special enrollment period. If you are enrolled in the *Plan*, you will be allowed to switch plans during annual open enrollment.

### **Are there any other exceptions for enrollment?**

### **Special Enrollment Periods**

This Plan provides three special enrollment periods that allow you to enroll in the Plan, even if you declined enrollment during your eligibility period.

#### **1. Loss of Other Coverage**

If you declined enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your dependents if the other health coverage is lost. You must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

### **The following conditions apply to any eligible employee and dependents:**

#### **You may enroll during this special enrollment period:**

- If you are eligible for coverage under the terms of this Plan;
- You are not currently enrolled under the Plan;
- When enrollment was previously offered, you declined because of coverage under another group health plan. You must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan, and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), because of termination of the other coverage and no substitute was offered, or because employer contributions for the coverage were terminated.

## **ELIGIBILITY FOR PARTICIPATION (CONTINUED)**

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### **You are not eligible for this special enrollment right if:**

- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

You or your dependent(s) must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended. The Plan will assume that the written explanation of benefits (EOB) form is received five calendar days after the Plan mails the EOB form. If the conditions for special enrollment are satisfied, coverage for you and/or your dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

### **2. Eligibility for State Premium Assistance Subsidy or Loss of Coverage under a Medicaid or SCHIP Plan**

You or your dependent(s) may enroll in the Plan if you lose coverage or become eligible for state premium assistance subsidy under either a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program under Title XXI of the Social Security Act (SCHIP). You must make written application for special enrollment within 60 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on November 15.

### **The following conditions apply to any eligible employee and dependents:**

#### **You may enroll during this special enrollment period:**

- If you are eligible for coverage under the terms of this Plan;
- You are not currently enrolled under the Plan;

### **3. New Dependent**

If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your newly acquired dependents during a special enrollment period. You must make written application for special enrollment no later than 31 days after you acquire the new dependent. For example, if you are married on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

### **The following conditions apply to any eligible employee and dependents:**

#### **You may enroll yourself and/or your eligible dependents during this special enrollment period if:**

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new dependent through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your dependent(s) will be effective at 12:01 A.M.:

- If you acquire a dependent through marriage while you are eligible for coverage for dependents, coverage for the newly acquired dependents will be effective on the date of the
- Marriage, provided you make written application for the dependent and agree to make any required contributions, within 31 days of the date of marriage.

## **ELIGIBILITY FOR PARTICIPATION (CONTINUED)**

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- For an adoption or placement for adoption, on the date of the adoption or placement for adoption provided the adoption (or placement for adoption) occurs while you are covered under the Plan and provided written application for coverage is made within 31 days of the adoption (or placement for adoption).
- For a dependent child who is born after the date your coverage becomes effective:
  - On the date of birth if family coverage is in effect.
  - On the date of birth if single coverage is in effect and you make written application and agree to any required contributions during the first 31 days from the child's birth. Coverage for the dependent child will then become effective from the moment of birth.

### **What if a court orders coverage for a child?**

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a "medical child support order" ("MCSO") or "national medical support notice" ("NMSN") that is a "qualified medical child support order" ("QMCSO") if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

"Alternate recipient" shall mean any child of a covered person who is recognized under a MCSO as having a right to enrollment under this Plan as the covered person's eligible dependent. "MCSO" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a covered person's child or directs the covered person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

"NMSN" shall mean a notice that contains the following information:

- Name of an issuing state agency;
- Name and mailing address (if any) of an employee who is a covered person under the Plan;
- Name and mailing address of one or more alternate recipients (i.e., the child or children of the covered person or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)); and
- Identity of an underlying child support order.

"QMCSO" is an MCSO that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a covered person or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the covered person and the name and mailing address of each alternate recipient covered by the order;

## **ELIGIBILITY FOR PARTICIPATION (CONTINUED)**

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- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this Plan.

In addition, a NMSN shall be deemed a QMCSO if it:

- Contains the information set forth above in the definition of "NMSN";
  - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the employer and the Plan Administrator will assume that all are designated; or
  - Informs the Plan Administrator that, if a group health plan has multiple options and the covered person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

**However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to covered persons without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO's, as described in Social Security Act §1908.**

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

- Notify the covered person and each alternate recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and
- Make an administrative determination if the order is a QMCSO and notify the covered person and each affected alternate recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - Whether the child is covered under the Plan; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

## **ELIGIBILITY FOR PARTICIPATION (CONTINUED)**

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To give effect to this requirement, the Plan Administrator shall:

- Establish reasonable, written procedures for determining the qualified status of a MCSO or NMSN; and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the order.

### **Reinstatement of Coverage**

An employee's coverage under the Plan may be reinstated if such coverage terminated due to a layoff or an approved leave of absence and the employee returns to active full-time or part-time employment as an eligible employee for the employer within 90 days from the date on which the layoff or approved leave of absence began. Coverage under the Plan will become effective on the date of return to active employment as an eligible employee. The employee must make written application for coverage within 31 days following the date of return to active employment. If written application for coverage is made after 31 days of the effective date of coverage, you will not be eligible for enrollment in the Plan, except as allowed under the special enrollment provisions of the Plan.

## **SELECTION OF YOUR HEALTH CARE PROVIDER**

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### **Overview of PPO/Non-PPO Option**

The Plan Administrator has entered into an agreement with one or more networks of hospitals and physicians, called "PPO networks." These PPO networks offer covered persons health care services at discounted rates. Using a PPO network provider will normally result in a lower cost to the Plan as well as to the covered person. There is no requirement for any covered person to seek care from a provider who participates in the PPO network. The choice of provider is entirely up to the covered person.

If you reside outside the PPO network area, and use a non-PPO network provider, your benefits will be based on the "Out of Area" level shown in the "Schedule of Benefits." This also applies to dependent children who are covered by this Plan, and reside outside the network area.

A current list of PPO network providers is available, without charge, through the third party administrator or through the website located at [www.securityhealth.org](http://www.securityhealth.org). You may also contact your PPO network at the phone number on your Plan ID card.

Each covered person has a free choice of any provider, and the covered person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO network provider.

### **INFORMATION REGARDING THE WRAP NETWORK**

Security Administrative Services (SAS) participates with a national provider network that allows members to access provider discounts when outside the SAS network. Whenever a covered person access health care services outside the geographic area served by the SAS network, the claims for those covered services may be re-priced and presented to SAS for payment on behalf of the Plan. Under the Wrap Network, when a covered person receives covered services from a provider contracted with the Wrap Network and outside the geographic area served by the SAS network SAS will remain responsible to the Plan for fulfilling all contract obligations. However, in accordance with the Wrap Network policies, the Wrap Network will only be responsible for providing such services as contracting with its participating providers and handling all interaction with its participating providers.

## **SELECTION OF YOUR HEALTH CARE PROVIDER (CONTINUED)**

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Many PPO network providers will require that the Plan offer incentives, or “steerage,” in order to encourage covered persons to use their member providers. This Plan defines “steerage” as lower costs to the covered person through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the Plan. The Plan Administrator reserves the right to negotiate discounts with providers of service, and those discounts will be used to reduce the amount of otherwise covered expenses considered for payment by the Plan. In certain cases, the Plan

Administrator, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the PPO network provider reimbursement level, and such payments will be considered to be in full compliance with the terms of the Plan.

## **YOUR COSTS**

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You must pay for a certain portion of the cost of covered expenses under the Plan, including deductibles, copayments and the coinsurance percentage that is not paid by the Plan. This is called "out-of-pocket expense."

Deductibles and copayments are shown in the "Schedule of Benefits." A separate deductible applies to charges from PPO network providers and another for non-PPO network providers. If you use a combination of PPO network providers and non-PPO network providers, your total deductible amount required will not exceed the amount shown for non-PPO network providers. In other words, the amount of deductible expense you pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a single plan year. The Plan limits the amount of deductible and out-of-pocket expense you must pay for your family unit, as shown in the "Schedule of Benefits."

There may be differences in the coinsurance percentage payable by the Plan depending upon whether you are using a PPO network provider or a non-PPO network provider. These payment levels are also shown in the "Schedule of Benefits."

The Plan contains a limit for the amount of out-of-pocket expense you must pay toward covered expenses, shown in the "Schedule of Benefits," and your out-of-pocket expense limit may be higher for non-PPO network providers than for PPO network providers. Please note, however, that not all covered expenses are eligible to accumulate toward your out-of-pocket expense limit. These types of expenses include:

- Charges for services and supplies rendered that are not considered covered expenses under the Plan

Reimbursement for these types of covered expenses will continue at the percentage payable shown in the "Schedule of Benefits," subject to the Plan maximums. In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the "Schedule of Benefits" section. Expenses in excess of these plan limits will not accumulate toward the out-of-pocket expense limit.

Once you have paid the out-of-pocket expense limit for eligible expenses incurred during a plan year, the Plan will reimburse additional eligible covered expenses incurred during that year at 100%.

The Plan will not reimburse any expense that is not a covered expense. In addition, you must pay any expenses to which you have agreed that are in excess of the usual, customary and reasonable fees, and any penalties for failure to comply with requirements of the "Cost Containment Provisions" section or penalties that are otherwise stated in the Plan. None of these amounts will accumulate toward your out-of-pocket expense limit.

If you have any questions about whether an expense is a covered expense, or whether it is eligible for accumulation toward your out-of-pocket expense limit, please contact the third party administrator for assistance.

**SCHEDULE OF BENEFITS**

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**Base Plan**

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<b>Your Responsibilities</b>	<b>In network</b>	<b>Out of network</b>
<b>Deductible</b> The individual Deductible does not apply under a family plan. One or more members must meet the family deductible before benefits will be paid.	\$2,000 individual \$4,000 family	\$4,000 individual \$8,000 family
<b>Coinsurance</b>	20%	40%
<b>Annual out of pocket (Deductible &amp; coinsurance)</b>  In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	\$3,000 individual \$6,000 family  Only the family limit above applies to a family plan.	\$6,000 individual \$12,000 per family  Only the family limit above applies to a family plan.
<b>Common Accident Deductible:</b> If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.		
<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Ambulance services</b>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b>		
<ul style="list-style-type: none"> <li>• <b>Office Visit</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Therapies, manipulations, and X-rays</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations (diagnostic)</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Home health care</b> <ul style="list-style-type: none"> <li>Limited to 40 visits per calendar year.</li> <li>Additional 40 visits available if terminally ill (hospice).</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services</b>		
<ul style="list-style-type: none"> <li><b>Emergency room facility</b></li> </ul>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Other emergency room services</b></li> </ul>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Hospital inpatient services</b> <ul style="list-style-type: none"> <li><b>Precertification required</b> (Including semi-private or special care room, operating room, ancillary services and supplies)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity services</b>		
<ul style="list-style-type: none"> <li><b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Physician services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Mental health and substance abuse services</b>		
<ul style="list-style-type: none"> <li><b>Inpatient care</b> (Pre-certification required)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Outpatient office visit</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Transitional care</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Testing and evaluation</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Office Visit</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient laboratory Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Outpatient therapy services</b>		
<ul style="list-style-type: none"> <li>• <b>Medical Biofeedback</b> (As part of an approved pain management program)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Occupational therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Physical therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Speech therapy</b> (Refer to the SPD for specific limitations)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Physician services</b>		
<ul style="list-style-type: none"> <li>• <b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Other services in an office</b></li> </ul>	Subject to deductible and coinsurance  (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
<p><b>Preventive benefit</b> Please refer to Security Administrative Services' Preventive Service Guidelines at <a href="http://www.securityhealth.org">www.securityhealth.org</a> under Health Care Reform for service frequency recommendations.</p>		
<ul style="list-style-type: none"> <li>• <b>Comprehensive physical examination</b> (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care</li> </ul>	Covered at 100%	Covered at 100%
<ul style="list-style-type: none"> <li>• <b>Gynecological examination for women</b> (breast exam and pelvic exam)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Digital prostate examination for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li><b>Pap smear to screen for cervical cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 every two years then subject to deductible and coinsurance	1 per two years then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Other screenings for colorectal cancer</b> <ul style="list-style-type: none"> <li>~ Sigmoidoscopy</li> <li>~ Double contrast barium enema</li> <li>~ Fecal occult blood testing</li> </ul> </li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Screening laboratory services</b> Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.</li> </ul>	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Bone mineral density (dexa scan) to screen for osteoporosis in women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Chlamydia screening for women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Ultrasound for screen of an abdominal aortic aneurysm for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Immunizations and vaccinations (including those needed for travel)</b></li> </ul>	Covered at 100%	Covered at 100%
<b>Skilled nursing facility</b> <ul style="list-style-type: none"> <li><b>Limited to 107 days per calendar year</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Temporomandibular joint disorders or TMJ nonsurgical treatment</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Transplant services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Vision examinations (diagnostic)</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>All other covered</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Wellness Benefit</b> The following routine services are covered up to the \$600 maximum per participant and no further benefits are available for the remainder of the calendar year:		
<ul style="list-style-type: none"> <li>• <b>Health Fitness Organizations</b> (Must attend 8 sessions per month)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine Dental Care</b> (Limited to 2 exams and 1 X-ray. Teeth cleaning with fluoride. Sealants for children under 15.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Smoking Cessation</b> (Must attend 80% of sessions per month.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Sports Physical</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine vision exam and refraction including frames and lenses</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine hearing care including hearing checks</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Weight Loss Programs</b> (Must attend 80% of sessions per month.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<b>Pharmacy</b>		
<b>Limited to a 90 day supply for both retail and mail order.</b>	Subject to deductible and coinsurance.  100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products.	

**SCHEDULE OF BENEFITS (CONTINUED)****Mid Plan**

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<b>Your Responsibilities</b>	<b>In network</b>	<b>Out of network</b>
<b>Deductible</b>	\$750 individual \$1,750 family	\$1,500 individual \$3,500 family
<b>Coinsurance</b>	20%	40%
<b>Annual Medical out of pocket</b> (Deductible, coinsurance and medical copays)  In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	\$1,750 individual \$4,750 family	\$3,500 individual \$9,500 per family
<b>Annual Prescription out of pocket</b>	\$4,850 individual \$8,450 family	
<b>Common Accident Deductible:</b> If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.		
<b>Deductible Carryover:</b> If a covered person incurs eligible charges during the period beginning October 1 through December 31 which are applied to the deductible for that calendar year, these charges are also applied toward satisfaction of the deductible for the subsequent calendar year.		
<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Ambulance services</b>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b>		
• <b>Office Visit</b>	\$45 copay then subject to deductible and coinsurance	\$45 copay then subject to deductible and coinsurance
• <b>Therapies, manipulations, and X-rays</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations (diagnostic)</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> <ul style="list-style-type: none"> <li>Limited to 40 visits per calendar year.</li> <li>Additional 40 visits available if terminally ill (hospice).</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services</b>		
<ul style="list-style-type: none"> <li><b>Emergency room facility</b> (Copayment waived if admitted to hospital as inpatient)</li> </ul>	\$150 copayment per visit then subject to coinsurance.	\$150 copayment per visit then subject to in network coinsurance.
<ul style="list-style-type: none"> <li><b>Other emergency room services</b></li> </ul>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Hospital inpatient services</b> <ul style="list-style-type: none"> <li><b>Precertification required</b> (Including semi-private or special care room, operating room, ancillary services and supplies)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity services</b>		
<ul style="list-style-type: none"> <li><b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Physician services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Mental health and substance abuse services</b>		
<ul style="list-style-type: none"> <li><b>Inpatient care</b> (Pre-certification required)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Outpatient Office Visit</b></li> </ul>	\$45 copay then subject to coinsurance	\$45 copay then subject to coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li>• <b>Testing and evaluation</b></li> </ul>	100% of first \$500, then subject to coinsurance	100% of first \$500, then subject to coinsurance
<ul style="list-style-type: none"> <li>• <b>Transitional care</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Office visit</b>	\$30 copay for primary care provider, \$45 copay for specialist. Balance subject to coinsurance.	\$30 copay for primary care provider, \$45 copay for specialist. Balance subject to coinsurance.
<b>Outpatient laboratory Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient therapy services</b>		
<ul style="list-style-type: none"> <li>• <b>Medical Biofeedback</b> (As part of an approved pain management program only)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Occupational therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Physical therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Speech therapy</b> (Refer to the SPD for specific limitations)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Physician services</b>		
<ul style="list-style-type: none"> <li>• <b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Other services in an office</b></li> </ul>	Subject to deductible and coinsurance  (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
<b>Preventive benefit</b> Please refer to Security Administrative Services' Preventive Service Guidelines at <a href="http://www.securityhealth.org">www.securityhealth.org</a> under Health Care Reform for service frequency recommendations.		

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li>• <b>Comprehensive physical examination</b> (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care</li> </ul>	Covered at 100%	Covered at 100%
<ul style="list-style-type: none"> <li>• <b>Gynecological examination for women</b> (breast exam and pelvic exam)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Digital prostate examination for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Pap smear to screen for cervical cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 every two years then subject to deductible and coinsurance	1 every two years then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Other screenings for colorectal cancer</b> ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing</li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Screening laboratory services</b> Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.</li> </ul>	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Bone mineral density (dexa scan) to screen for osteoporosis in women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li>• <b>Chlamydia screening for women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Ultrasound for screen of an abdominal aortic aneurysm for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Immunizations and vaccinations (including those needed for travel)</b></li> </ul>	Covered at 100%	Covered at 100%
<b>Skilled nursing facility</b> <ul style="list-style-type: none"> <li>• <b>Limited to 107 days per calendar year</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Temporomandibular joint disorders or TMJ nonsurgical treatment</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Transplant services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Vision examinations (diagnostic)</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>All other covered</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Wellness Benefit</b> The following routine services are covered up to the \$600 maximum per participant and no further benefits are available for the remainder of the calendar year:		
<ul style="list-style-type: none"> <li>• <b>Health Fitness Organizations (Must attend 8 sessions per month)</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine Dental Care (Limited to 2 exams and 1 X-ray. Teeth cleaning with fluoride. Sealants for children under 15.)</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Smoking Cessation (Must attend 80% of sessions per month.)</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li>• <b>Sports Physical</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine vision exam and refraction including frames and lenses</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine hearing care including hearing checks</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Weight Loss Programs</b> (Must attend 80% of sessions per month.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<b>Pharmacy</b>		
<p><b>Prescriptions that are available in generic must be received in generic or the insured will pay the difference in the cost between the generic and name brand. The difference will not apply towards the prescription out of pocket.</b></p> <p><b>Limited to a 90 day supply for both retail and mail order.</b></p>	<p>5% of total cost per tier 1 prescription or refill.            20% of total cost per tier 2 prescription or refill.            25% of total cost per tier 3 prescription or refill.            30% of total cost per tier 4 prescription or refill to annual maximum of \$2500.</p> <p>Prescriptions will have an out of pocket of maximum of \$4,850/individual or \$8,450/family.</p>	

## **MEDICAL BENEFITS**

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### **Hospital Inpatient Benefits**

#### **Inpatient Care**

For medical or surgical care of an illness or injury, the Plan will reimburse covered expenses for semi-private room and board and necessary ancillary expenses. If the hospital does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area

Covered expenses will include cardiac care units and intensive care units, when appropriate for the covered person's illness or injury.

#### **Maternity Care**

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are payable in the same manner as for medical or surgical care of an illness, shown in the "Schedule of Benefits" and this section, and subject to the same maximums.

#### **Newborn Care**

Coverage for a newborn child will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

Covered expenses for newborn children include nursery and neo-natal intensive care room and board, necessary ancillary expenses, and routine newborn care during the period of hospital confinement, including circumcision.

#### **Skilled Nursing (or Extended Care) Facilities Benefits**

Covered expenses for inpatient skilled nursing or (extended care) facilities include semi-private room and board accommodations, and necessary ancillary charges. The confinement must begin following an inpatient stay of at least one day in a hospital and must be for continued treatment of the illness or injury being treated in the hospital.

#### **Rehabilitation Facilities Benefits**

Covered expenses for inpatient rehabilitation facilities include semi-private room and board accommodations and necessary ancillary charges. The confinement must begin following an inpatient stay of at least one day in a hospital and must be for continued treatment of the illness or injury being treated in the hospital.

#### **Mental or Nervous Disorder and Substance Abuse Inpatient, Outpatient and Partial Hospitalization Services**

Eligible charges for inpatient, outpatient and transitional treatment for Mental Health and Substance Abuse are covered as specified on the Schedule of Benefits. Treatment must be rendered in a facility approved or licensed in the state in which it is located or by use of telehealth services.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Mental or Nervous Disorder Inpatient and Partial Hospitalization**

Covered expenses for inpatient care of a mental or nervous disorder include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or psychiatric treatment facility.

If the hospital or psychiatric treatment facility does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area.

### **Substance Abuse Inpatient and Partial Hospitalization**

Covered expenses for inpatient care of substance abuse include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or substance abuse treatment facility. If the hospital or substance abuse treatment facility does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area.

### **Outpatient Mental or Nervous Disorder and Substance Abuse Services**

#### **Outpatient Mental or Nervous Disorder Care**

Covered expenses include outpatient mental or nervous disorder care by a licensed psychologist, psychiatrist, or social worker, if the social worker services are under the direct supervision of a physician.

#### **Outpatient Substance Abuse Care**

Covered expenses include outpatient substance abuse care by a licensed provider.

### **Physicians' In-Hospital Services**

#### **In-Hospital Medical Services**

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

#### **In-Hospital Concurrent Medical Care**

Covered expenses include services rendered concurrently by a physician other than the attending physician when the covered person is being treated for multiple, unrelated illnesses or injuries, or which require the skills of a physician specialist.

#### **In-Hospital Consultant Services**

Covered expenses include the services of a physician consultant when required for the diagnosis or treatment of an illness or injury.

#### **Mental or Nervous Disorder In-Hospital Medical Care Services**

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

#### **Substance Abuse In-Hospital Medical Care Services**

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Surgical Inpatient and Outpatient Services**

#### **Anesthesia Services**

Covered expenses include the administration of spinal, rectal or local anesthesia, or a drug or other anesthetic agent by injection or inhalation, rendered by a licensed provider. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA). Covered expenses do not include anesthesia administered by the surgeon physician.

#### **Surgical Assistants**

Covered expenses include services by a licensed physician who actively assists the operating surgeon in the performance of surgical procedures when the condition of the patient and complexity of the surgery warrant such assistance. Benefits are also provided for these services when rendered by a licensed surgical physician's assistant.

#### **Obstetrical Services**

Covered expenses include obstetrical services rendered by the physician in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the Plan provisions in effect on the date the services are rendered.

#### **Surgical Services**

Covered expenses include surgical procedures, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one surgical procedure is performed during the same operative session, the allowed expense is calculated as follows:

- 100% of the covered expense, after any PPO network provider discount, for the most complex procedure.
- 50% of the covered expense, for the second and each subsequent procedure.
- No benefit is payable for incidental procedures (such as an appendectomy during abdominal surgery)

#### **Professional Interpretation Services Inpatient and Outpatient**

Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an illness or injury, unless otherwise provided under "Preventive Care."

#### **Hospital Emergency Room Services**

Covered expenses include:

- Emergency treatment of an accidental injury.
- Emergency treatment of an illness.
- Covered expenses also include physician's charges, and charges for radiology and pathology, for emergency surgical or medical care rendered in the hospital emergency room.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Outpatient Facility Fees**

Covered expenses include the following services when provided in an outpatient department of a hospital or other institution:

### **Outpatient Diagnostic Examinations**

Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an illness or injury.

### **Pre-Admission Testing**

Benefits are provided for pre-admission testing for expenses incurred prior to the scheduled hospital admission, and only when the testing is not duplicated on admission.

### **Outpatient Surgery/Ambulatory Surgery Center**

Benefits are provided for charges by a hospital, ambulatory surgical center, or in a physician's office, for services required for a surgical procedure. The facility fees may include both services and supplies required for the surgery.

### **Biofeedback Services**

Benefits are provided for biofeedback only as part of an approved pain management program.

### **Cardiac Rehabilitation**

Benefits are provided for cardiac rehabilitation program services when certified as medically necessary by the attending physician in a treatment program that is appropriate for the covered person's illness.

### **Chemotherapy Services**

Benefits are provided for administration of chemotherapy treatment, including the usual, customary and reasonable fee for Drugs and supplies used during the treatment.

### **Dialysis**

Benefits are provided for kidney dialysis treatment, including the usual, customary and reasonable fee for Drugs and supplies used during the treatment.

### **Intravenous Therapy**

Benefits are provided for administration of intravenous therapy, including the usual, customary and reasonable fee for Drugs and supplies used during the treatment.

### **Occupational Therapy**

Benefits are provided for occupation therapy to restore a covered person to health, or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the covered person's ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending physician as part of a treatment plan that is appropriate for the covered person's illness or injury.

### **Physical Therapy**

Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following illness, injury or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the illness or injury, and which is ordered by the attending physician.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Radiation Therapy**

Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the usual, customary and reasonable fee for materials.

### **Speech Therapy**

Covered only when the therapy is medically necessary due to an accidental injury, surgery or organic pathological disorder such as a stroke; or for developmental delay to age 3. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the illness or injury, and which is ordered by the attending physician.

### **Temporomandibular Joint Dysfunction**

Eligible charges are covered as specified on the Schedule of Benefits for the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ), provided the condition is caused by a congenital developmental or acquired deformity disease or injury; the procedure or device is medically necessary for the diagnosis or treatment of the condition; and the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices. Cosmetic or elective orthodontic care, periodontic care or general dental care is not covered. Charges are subject to all provisions of the Plan.

### **Physician's Office Services**

Covered expenses include the following services rendered in a physician's office:

#### **Office Visits**

Benefits are provided for services given in a physician's office which are required for the diagnosis or treatment of an illness or injury. Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

#### **Allergy Care**

Benefits are provided for allergy care, including injections, serums and extracts, given in a physician's office. Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

#### **Injections**

Benefits are provided for therapeutic injections given in a physician's office which are required for the treatment of an illness or injury. Immunizations and other injections which are not for the treatment of an illness or injury are not covered unless specified under "Preventive Care." Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

#### **Diagnostic X-ray and Laboratory Services**

Benefits are provided for diagnostic X-ray and laboratory services given in a physician's office, which are required for the diagnosis or treatment of an illness or injury. Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

#### **Chiropractic Care Services**

Eligible charges for chiropractic care including X-rays, manipulations and supportive care are covered as specified on the Schedule of Benefits. Supportive care means treatment which is medically necessary to prevent the covered person's condition from significantly deteriorating. Maintenance care is routine and is not medically necessary for treatment of a condition. Maintenance care is not covered by the Plan.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Preventive Care Benefit**

Covered expenses include these listed services for preventive care for each covered person, subject to any limits described in the "Schedule of Benefits" section. The preventive care benefit includes services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force, immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings for infants, children, adolescents and women by the Health Resources and Services Administration.

- Preventive Examination;
- Well Baby Care;
- Immunizations;
- Flu Shot;
- PSA (Prostate Specific Antigen) Test;
- Mammogram Test;
- Pap Test;
- Colonoscopy;
- Prostate Exam;
- Fecal Occult Blood Test;
- Preventive Laboratory Services;
- Bone Density Study;
- Abdominal Aortic Aneurysm (AAA) Ultrasound screening (for Men);
- Chlamydia Screening (for Women).

### **Wellness Benefit**

The following routine services are covered up to the \$600 maximum per participant regardless of provider or program network participation, and no further benefits are available for the remainder of the calendar year:

- Routine Vision including exam, refraction and vision hardware including frames and lenses, hardware does not include special services such as polishing, tinting and scratch coating.
- Routine Hearing Exam
- Routine Dental Care, inclusive of 2 examinations, one X-ray, teeth cleaning with fluoride. Sealants for children under the age of 15.
- Sports Physical
- Health Fitness Organization (Must attend 8 session per month)

## **MEDICAL BENEFITS (CONTINUED)**

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- Smoking Cessation Program (Must attend 80% of sessions per month.)
- Weight Loss Program (Must attend 80% of sessions per month.)

### **Second Surgical Opinions**

Covered expenses include a second opinion to determine the medical necessity for a recommended surgical procedure. The physician rendering the second opinion must not be affiliated with the physician who recommended the surgical procedure. A third opinion will be covered if the two opinions differ, and if it is performed by a physician who is not affiliated with the physicians who have rendered opinions.

### **Other Covered Expenses**

#### **Ambulance Service**

Covered expenses include local professional ambulance service from your home to a hospital, or from the scene of an accident or medical emergency, to the nearest institution able to treat the condition.

Air ambulance services will be covered when medically necessary to transport the covered person to the nearest institution capable of treating the illness or injury.

#### **Autism Services**

The following benefits for treatment of autism spectrum disorder are subject to any applicable deductible, coinsurance or copayments and limited to the dollar amounts on your Schedule of Benefits. The treatment must be prescribed by a physician and provided by persons who are qualified to provide intensive level services or non-intensive level services as described in section 632.895 (12m), Stats. and in Ins 3.36, Wisconsin Administrative Code:

- Diagnosis – The Plan shall provide coverage to the extent described in the above paragraph for services to a participant that has a primary verified diagnosis of autism spectrum disorder, as determined by the third party administrator.

The Plan will provide coverage of the diagnostic testing in addition to the benefits described below. For the diagnosis to be valid for autism spectrum disorder, the testing tools shall be appropriate to the presenting characteristics and age of the participant and be empirically validated for autism spectrum disorders to provide evidence that the participant meets the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The Plan may require confirmation of a primary diagnosis through completion of empirically validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child. The Plan may require a participant to obtain a second opinion from a provider experienced in the use of empirically validated tools specific for autism spectrum disorders that is mutually agreeable to the participant or the participant's parent or authorized representative and to the third party administrator. The Plan will pay benefits for the second opinion.

The Plan may require that the assessment include both a standardized parent interview regarding current concerns and behavioral history as well as direct, structured observation of social and communicative behavior and play. The diagnostic evaluation should also assess those factors that are not specific to an autism spectrum disorders including degree of language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders.

## **MEDICAL BENEFITS (CONTINUED)**

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

- Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the participant be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the participant's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the participant's family and treatment team for implementation of the therapeutic goals developed by the team.
- Commenced after a participant is two years of age and before the participant is nine years of age.
- The participant is directly observed by the qualified provider at least once every two months.

The Plan shall credit against the four years of intensive-level services any previous intensive-level services the participant received regardless of payor. The Plan may require documentation including medical records and treatment plans to verify any evidenced-based behavioral therapy the participant received for autism spectrum disorders that was provided to the participant prior to the participant attaining nine years of age. The Plan may consider any evidence based behavioral therapy that was provided to the participant for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

Progress must be assessed and documented throughout the course of treatment. The Plan may request and review the participant's treatment plan and the summary of progress on a periodic basis.

- Non-intensive level services- The Plan shall provide coverage for a participant with a verified diagnosis of autism spectrum disorder for non-intensive level services, subject to a benefit maximum as shown in your schedule of benefits, that are evidence-based and that are provided to a participant by a qualified provider, professional, therapist or paraprofessional in either of following conditions:
  - After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment.
  - To a participant who has not and will not receive intensive-level services but for whom non-intensive level services will improve the participant's condition.

Such services must meet all of the following requirements:

- Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of

## **MEDICAL BENEFITS (CONTINUED)**

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- autism spectrum disorders. Treatment plans shall require that the participant be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals
- Provided in an environment most conducive to achieving the goals of the participant's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the participant's family in order to implement the therapeutic goals developed by the team.
- Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

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

Progress must be assessed and documented throughout the course of treatment. The Plan may request and review the participant's treatment plan and the summary of progress on a periodic basis.

- Transition to non-intensive level services – The Plan shall provide notice to the participant or the participant's authorized representative regarding change in a participant's level of treatment. The notice shall indicate the reason for transition that may include any of the following:
  - The participant has received four cumulative years of intensive-level services.
  - The participant no longer requires intensive-level services as supported by documentation from a qualified provider or supervising provider.
  - The participant no longer receives evidence-based behavioral therapy for at least 20 hours per week over a six-month period of time.

A participant or a participant's authorized representative must timely notify the third party administrator if the participant requires and qualifies for intensive-level services but the participant or the participant's family or care giver is unable to receive intensive-level services for an extended period of time. The participant or the participant's authorized representative shall indicate the specific reason or reasons the participant or the participant's family or care giver are unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason the Plan determines to be acceptable.

The Plan will not deny intensive-level services to a participant for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a six-month period when the participant or the participant's authorized representative complied with the paragraph above or the participant or the participant's authorized representative can document that the participant failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

- Coverage amounts – The coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The Plan may not provide coverage for the listed monetary amounts or durations if it is determined by a supervising professional, in consultation with the participant's physician, that less treatment is medically appropriate.

## **MEDICAL BENEFITS (CONTINUED)**

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### **The following limitations and exclusions apply to this section only:**

- acupuncture
- animal-based therapy including hippo therapy
- auditory integration training
- chelation therapy
- child care fees
- cranial sacral therapy
- custodial or respite care
- hyperbaric oxygen therapy
- special diets or supplements
- claims that have been determined to be fraudulent
- treatment rendered by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessional for treatment rendered to their own children.
- treatments in a school facility that are not related to the goals of the treatment plan or duplicate services that are required to be provided by a school
- for therapy, treatment or services when provided to a participant who is residing in a residential treatment center, inpatient treatment or day treatment facility
- the cost for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside a participant's home
- travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals

Coverage is not provided for pharmaceuticals or durable medical equipment under this paragraph. Such coverage shall be provided consistent with the terms of the participant's plan.

### **The following definitions apply to this section only:**

**Autism spectrum disorder** – means any of the following:

1. autism disorder
2. Asperger's syndrome
3. pervasive developmental disorder not otherwise specified

**Evidence-based** – means therapy that is based upon medical and scientific evidence as defined at s. 632.835 (3m) (b) 1, 2, and 2.a., Stats., and s. Ins 18.10 (4), Wisconsin Administrative Code and is determined to be an efficacious treatment or strategy.

**Efficacious treatment or efficacious strategy** – means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve an individual with autism spectrum disorder's condition.

To be sufficient to demonstrate that a treatment or strategy, when used solely or in combination with other treatments or strategies, is effective in addressing the cognitive, social, and behavioral challenges associated with autism spectrum disorders or demonstrating significant improvement, Research designs for the treatment or strategy must meet the standards described in s. Ins 3.36(7), Wisconsin Administrative Code.

**Intensive-level services** – means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder. They are directly based on, and related to, a participant's therapeutic goals and skills as prescribed by a physician familiar with the participant.

## **MEDICAL BENEFITS (CONTINUED)**

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**Non-intensive level services** – means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

**Physician** – has the meaning given in s. 146.34 (1)(g), Stats.

The terms **behavioral, provider, qualified provider, qualified paraprofessional, qualified professional, qualified supervising provider, qualified therapist, therapy, therapist, and waiver program** – shall have the meanings given in s. 632.895(12m), Stats. and s. Ins 3.36, Wisconsin Administrative Code.

### **Durable Medical Equipment**

Covered expenses include rental of durable medical equipment. The Plan may approve purchase of the equipment at the Plan Administrator's discretion. Benefits for rental will not exceed the usual, customary and reasonable fee for purchase.

**Purchase or rental of:** exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts; are not covered

### **Home Health Care**

Covered expenses include home health services when rendered by a licensed and accredited home health care agency. These services must be provided through a formal, written home health care treatment plan, certified as medically necessary by the attending physician, and approved by the Plan. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family.
- Physical, occupational, respiratory and speech therapy.
- Services provided by a licensed social worker (M.S.W.).
- Services provided by a home health aide.

On-going home health services will require pre-certification by the attending physician and approval by the Plan, at the Plan Administrator's discretion, in order to qualify for continued coverage.

The total benefits paid for home health care on a weekly basis may not exceed the amount the Plan would have paid if the covered person had been confined in a hospital, skilled nursing facility or other institution.

## **MEDICAL BENEFITS (CONTINUED)**

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### **Hospice Care**

Covered expenses include hospice care services for a terminally ill covered person when provided by a hospice care agency. The services must be provided through a formal, written hospice care treatment program and certified by the attending physician as medically necessary. Benefits are provided for:

- Room and board for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- Respite services.
- Counseling services by a licensed social worker or a licensed counselor.
- Bereavement counseling by a licensed social worker or a licensed counselor for the employee and/or covered dependent(s).

The attending physician must certify that the covered person is expected to continue to live for six months or less in order to qualify for this benefit. If the covered person lives beyond six months, the Plan will approve additional hospice care benefits on receipt of satisfactory evidence of the continued medical necessity of the services.

### **Other Covered Expenses Also Include:**

- **Abortion.**
- **Acupuncture.**
- **Blood transfusions and blood products**, to the extent not replaced. The Plan will not cover expenses in connection with autologous blood acquisition and storage.
- **Contraceptives.** for oral, injectable (Depo Provera) and implantable (Norplant) contraceptives.
- **Growth hormone therapy** as part of a treatment program approved by the Plan Administrator.
- **Hearing aids and cochlear implants**, and related treatment for infants and children under the age of 18 who are certified as hearing impaired by a physician or by an audiologist.
  - Services must be prescribed by a physician or an audiologist.
  - Limited to one hearing aid per ear per child every three years.
- **Infertility.** Charges for the diagnosis of infertility, unless otherwise specified by the Plan;
- **One set of lenses (contact or frame-type)** following surgery for cataracts.
- **Oxygen.**
- **Orthotics**, custom made and physician prescribed.

## **MEDICAL BENEFITS (CONTINUED)**

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- **Oral surgical procedures**, including:
  - surgical exposure or extraction of impacted teeth;
  - extraction of seven or more natural teeth at one time
  - excision of exostosis of the jaw and hard palate;
  - apicoectomy - excision of apex of tooth root;
  - external incision and drainage of cellulitis;
  - incision of accessory sinuses, salivary glands or ducts;
  - gingivectomy - excision of loose gum tissue to eliminate infection;
  - alveolectomy - the leveling of structures supporting teeth for the purpose of fitting dentures;
  - frenectomy – the cutting of tissue in the midline of the tongue;
  - removal of the retained (residual) root;
  - gingival curettage under general anesthesia
  - apical curettage;
  - excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination;
  - surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
  - treatment of fractures of facial bones.
- **Prenatal vitamins.**
- **Prosthetic devices and supplies**, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the covered person's physical structure and the current device cannot be made serviceable.
- **Reconstruction of a breast** following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphadenomas, in a manner determined in consultation with the attending physician and the covered person. Reimbursement will be made according to the "Schedule of Benefits" section by type of service.
- **R.N. and L.P.N.** private duty nursing services for outpatient care when medically necessary.
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an illness or injury.
- **Sterilization procedure, elective.**

## **MEDICAL BENEFITS (CONTINUED)**

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- **Vision services**, exams for the purpose of diagnosing and treating a medical condition of the eye. This does not include routine services for diagnosis of disorders of refraction and accommodation, including but not limited to, hypermetropia, myopia, astigmatism and presbyopia, except as specifically allowed under the preventive benefit.

### **Replacement of Organs/Tissues and Related Services**

The Plan Administrator strongly recommends that any covered person who is a candidate for any transplant procedure contact Security Administrative Services before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the Plan, before the actual services are rendered.

In addition, the Plan Administrator has made arrangements with selected providers, called United Resource Networks, where a covered person may receive care at a negotiated rate. Using a United Resource Networks provider will normally result in lower costs to the Plan and the covered person. Please contact Security Administrative Services at 1-800-570-8760 for additional information about United Resource Networks.

### **Covered expenses include the following types of transplants:**

#### **Solid Organs**

Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This Plan excludes transplantation of non-human organs.

#### **Bone Marrow Transplants**

Benefits are provided for medically necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

#### **Tissue Replacement**

Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices).

#### **Other Benefits Related to Transplantation**

#### **Benefits are also provided for:**

- The preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.
- Transportation of the covered person, if the organ recipient, to and from the site of the transplant procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow, or tissue.

- When the transplant recipient and donor are **both** covered under this Plan, payment for covered expenses is provided for both, subject to each covered person's respective benefit maximums.
- When the transplant recipient is covered under this Plan but the donor is not, payment for covered expenses is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

## **MEDICAL BENEFITS (CONTINUED)**

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- When the transplant recipient is not covered under this Plan but the donor is covered, payment for covered expenses attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

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

Eligible charges related to an organ or tissue transplant include for example hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility. Benefits will not be duplicated if they are available from another plan, an organization or Medicare.

**Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the Plan for prior approval of certain services. The following covered expenses must be incurred while coverage is in force under this Plan. Reimbursement will be made according to the "Schedule of Benefits," and will be subject to all Plan maximums, limitations, exclusions and other provisions.**

## **EXCLUSIONS AND LIMITATIONS**

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**The following exclusions and limitations apply to expenses incurred by all covered persons.**

This *Plan* will not reimburse any expense that is not a *covered expense*. With respect to any *injury* which is otherwise covered by the *Plan*, the *Plan* will not deny benefits provided for treatment of the *injury* if the *injury* results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This *Plan* does not cover any charge for services or supplies:

### **Exclusions and Limitations – Medical**

This Plan will not reimburse any expense that is not a covered expense. This Plan does not cover any charge for services or supplies:

- **Corsets and other support devices.**
- **Counseling.** For counseling, except as specifically the result of a mental or nervous condition, for:
  - Marital difficulties
  - Social maladjustment
  - Pastoral issues
  - Financial issues
  - Behavioral issues
  - Lack of discipline or other antisocial action.
- **Custodial care.** For custodial care or rest cures.
- **Chelation Therapy**
- **Dental prescriptions.** For dental prescriptions (e.g., Peridex, fluoride).
- **Dental.** That are related to dental treatment, except as specifically provided in this Plan.
- **Dental hospital and ambulatory surgery** charges including anesthetic charges except if the covered person is a child under the age of 5, or the covered person has a chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments that is likely to continue indefinitely.
- **Developmental delay and therapy** for learning disabilities; developmental delay regardless of cause; perceptual disorders; mental retardation or related conditions; behavior disorders; multiple handicapped; sensory deficit; motor dysfunction; and communication or articulation disorders including apraxia, dyspraxia and pervasive development disorders. Except as specifically covered under the autism benefit and the speech therapy benefit.
- **Durable medical equipment:** Purchase or rental of exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts;
- **Educational.** Related to education or vocational training, including work hardening programs.

## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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- This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be medically necessary by the Plan.
- **Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.
- **Experimental services**
  - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered experimental, and hence, not covered by this Plan.
- **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:
  - Hypnotists;
  - Naturopaths;
  - Rolfers; and
  - Marriage counselors.
- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.
- **Food supplements.** Related to food supplements or augmentation, in any form (unless medically necessary to sustain life in a critically ill person).
- **Foot care services, routine or palliative.** For routine foot care, including, but not limited to, supportive devices for the foot, cutting or removal of corns or calluses, bunions (except for capsular or bone surgery), fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized illness, injury or symptoms involving the foot.
- **Halfway house.**
- **Hospital admissions.** Charges for hospital admissions which are mainly for physical therapy or for diagnostic studies.
- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or drugs pertaining to sexual dysfunction or impotence not related to organic disease.
- **Infertility treatment.** In vitro fertilization, Gamete Intra-Fallopian transfer and all related services and supplies, transsexual surgery or treatment,
- **Marital counseling.** For marital counseling.
- **Massage therapy.** For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered illness or injury, and approved as medically necessary by the Plan Administrator,

## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed physician, except to the extent as required by the Patient Protection and Affordable Care Act.
- **Not medically necessary.** That are not medically necessary for the care and treatment of an injury or illness, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.
- **Obesity treatment.** For the purpose of weight loss unless they are determined to be medically necessary and limited to services furnished directly by a qualified medical provider.
  - This exclusion does not apply to benefits for surgical or non-surgical treatment of morbid obesity under a treatment plan that has been approved by the Plan Administrator.
- **Orthognathic surgery** (jaw realignment surgery) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- **Oral surgery,** unless otherwise specified by the Plan, charges for orthognathic surgery including osteotomy procedures, and LeForte I, II and III procedures;
- **Other coverage.** For charges which are reimbursable under through medical coverage provided by or available through any applicable "No-fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance.
- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an illness or injury that are solely for the personal comfort and convenience of the patient.
- **Personal hygiene.** For personal hygiene or convenience items.
- **Services** received from a dental or medical department, maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.
- **Sexual dysfunction.** That is not related to organic disease or any other artificial means of conception.
- **Sterilizations, including** procedures designed to reverse elective or medically necessary sterilizations.
- **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.
- **Travel.** For travel, even though prescribed by a physician.
- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.

## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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- **Vitamins.** For vitamins, except to the extent as required by the Patient Protection and Affordable Care Act.
- **Vocational training, including work hardening programs.**
- **Without approval.** Furnished without recommendation and approval of a physician acting within the scope of his or her license.
- **Work-related illness or injury.** Related to an illness or injury for which the covered person is entitled to benefits under any workers' compensation or similar law, whether or not benefits are claimed. This exclusion does not apply to a covered person who is not required State Law to be covered by Workers' Compensation or Occupational Disease Law or similar legislation.

### **Exclusions and Limitations – General**

This section applies to all benefits provided under any section of this summary plan description. This Plan does not cover any charge for services or supplies:

- **Absence of coverage.** That would not have been made in the absence of coverage.
  - This includes charges that are submitted to the Plan equal to any amount for which the provider has discounted fees or has "written off" amounts due.
- **Civil insurrection or riot.** Resulting from injuries incurred or exacerbated while participating in a civil insurrection or riot.
- **Complications.** That result from complications arising from a non-covered illness or injury, or from a non-covered procedure.
- **Cosmetic.** For cosmetic surgery or procedures, or aesthetic services (including complications arising therefrom).
  - This exclusion does not apply to procedures required as the result of an injury, or if approved as medically necessary for a covered illness.
  - This exclusion does not apply to reconstruction of a breast following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person.
- **Court-ordered services.** That are ordered by a court, or are otherwise performed pursuant to state statute or regulation, unless determined by the Plan Administrator, in its discretion, to otherwise be appropriate and covered.
- **Deductibles, Copayments and Coinsurance.** That are not payable due to the application of any specified deductible, copayment or coinsurance provisions of the Plan.
- **Excess.** That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Plan Administrator's determination of the usual, customary and reasonable fee for the particular service or supply.
- **Forms.** For the completion of medical reports, claim forms or itemized billings.

## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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- **HMO Services** – payment of benefits under this Plan are limited to co-copayments and/or deductibles not covered under an HMO and/or eligible charges that are specifically excluded under the HMO. There is no coverage under this Plan for any service, treatment or supply not covered by the HMO because the covered person chose to obtain such service, treatment or supply from a provider who is not an HMO participating provider or because the covered person did not obtain a referral as required by the HMO.
- **Government services.** To the extent paid, or which the covered person is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.
- **Illegal act.** Related to injuries sustained, or an illness contracted, during the commission, or attempted commission, of a felony or illegal occupation.
- **Immediate relative.** Provided by an immediate relative.
- **Late Claims.** For which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.
- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.
- **Missed appointments.** Related to missed appointments.
- **No legal obligation.** That are provided to a covered person for which the provider customarily makes no direct charge or for which the covered person is not legally obligated to pay.
- **Not actually rendered.** That are not actually rendered.
- **Not eligible.** That were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided for in this summary plan description.
- **Not specifically covered.** That are not specifically covered under the Plan.
- **Penalties.** That are related to failure to comply with any requirements for coverage under this Plan, or for any copayment amounts identified as a "penalty" in this summary plan description.
- **Prohibited by law.** For which the Plan is prohibited by law or regulation from providing
- **Subrogation.** That are not payable under the Plan by virtue of its subrogation provisions.
- **Tax and shipping.** For taxes and shipping charges levied on medically necessary items and services. This exclusion does not apply to surcharges required by law to be paid by the Plan in applicable states.
- **Third Party request, examinations and treatments,** such as those requested for employment, purchase of insurance or school; except immunizations that are required as part of schooling for medical careers.
- **Veteran's Administration hospital or a hospital** operated by one of the Uniformed Services for a service related condition.

## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication there from.

## **COST CONTAINMENT PROVISIONS**

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### **Pre-certification Program for Inpatient Services**

Inpatient care is normally the greatest part of the Plan's expenses and can be the most critical part of your treatment. Through the Plan's Pre-certification Program, it is possible to work with your attending physician to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the Plan unnecessary expense.

The program works by establishing a communication among you, your attending physician and the Pre-certification Program administrator to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification Program does not establish your eligibility for coverage under the Plan, nor does it approve the services for coverage or reimbursement under the Plan. Those responsibilities rest with the Plan Administrator.

Because communication is the basis for the program, the Plan requires that you contact the Pre-certification Program administrator at least three days before any non-emergency inpatient admission. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a \$200 penalty reducing eligible benefits that are otherwise payable.**

### **Urgent Care or emergency Admissions**

**Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program.** For urgent, emergency admissions, follow your physician's instructions carefully, and contact the Pre-certification Program administrator no later than the next business day after admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **Concurrent In-patient Review**

Once the inpatient setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your physician, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

## **COST CONTAINMENT PROVISIONS (CONTINUED)**

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**The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program. Failure to contact the Program administrator within the time limits specified in this section will result in a \$200 penalty reducing eligible benefits that are otherwise payable.**

The Pre-certification Program administrator for this Plan is:

Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
(800) 991-8109

### **Pre-certification Program for Outpatient Services**

The Plan's Pre-certification Program also includes certain outpatient services. These typically are services that may not be covered expenses or that involve an on-going course of treatment on an outpatient basis. The purpose of pre-certifying these services is to identify non-covered expenses, or Plan limitations, in advance of incurring the expenses.

The Program works by establishing a communication among you, your attending physician, and the Pre-certification Program administrator, to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification Program does not establish your eligibility for coverage under the Plan, nor does it approve the services for coverage or reimbursement under the Plan. Those responsibilities rest with the Plan Administrator.

Because communication is the basis for the Program, the Plan requires that you contact the Pre-certification Program administrator at least three days before the commencement of non-emergency services of the types listed in this section. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.**

### **Urgent or emergency Care**

**Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize life or health because of the requirements of this Program. Pre-certification of outpatient emergency care is not recommended or required under these circumstances.**

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

### **Concurrent Outpatient Review**

Once the outpatient treatment has pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your physician, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

## **COST CONTAINMENT PROVISIONS (CONTINUED)**

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**The Pre-certification Program administrator for this Plan is:**

Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
(800) 991-8109

**The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.**

**Some outpatient non-emergency services require prior authorization. You or your provider should contact Security Administrative Services for more information regarding these services.**

Even though a covered person pre-certifies, it does not guarantee that this Plan will pay for the medical care. The covered person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this Summary Plan Description.

### **PENALTY FOR NON-CERTIFICATION**

#### **Concurrent Stay Review Non-compliance Penalty**

If a covered person does not comply with the Concurrent Stay Review requirements, the first \$200.00 in eligible charges for inpatient care will not be payable. Any reduction in benefits must be paid by the covered person.

#### **Medical Case Management**

Medical Case Management focuses on acute or chronic conditions that result from serious or debilitating illnesses or injuries by coordinating the needs of the covered person, the family, the health care providers and the employer.

#### **Incentive Program**

##### **Medical Bill Audit Incentive Program**

This Plan provides incentives for helping locate errors on medical bills. Examples of which are charges billed but not received and charges incorrectly totaled. If the covered person suspects that an error has been made, he or she should follow the guidelines described below. The employee may be reimbursed 50% of the savings up to a maximum of \$1,000.00 per provider billing. This provision does not apply to duplicate billings. Errors totaling \$10.00 or less are not reimbursable.

1. Before a covered person leaves the hospital or medical facility, he or she should request an itemized bill from the patient accounts department;
2. Check the bill for errors, for example:
  - verify the number of inpatient days (room and board) for semi-private or intensive care;
  - verify the treatment, services or supplies which are charged for; and
  - verify that duplicate charges were not made for the same services.
3. A covered person should notify SAS by phone, within ten days of discharge or visit to the medical facility, that he or she is reviewing the bill;
4. SAS must receive a copy of the corrected itemized bill within one month after the date SAS is notified of the audit. SAS will then verify the error and reimburse the employee the eligible savings amount; and if SAS personnel initiate the investigation of billing errors, the benefit will not be payable.

## **PRESCRIPTION DRUG BENEFIT**

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Benefits are provided for the purchase of *drugs* through the Plan's Prescription Drug Card Program. The *covered person* must purchase the prescription *drugs* through the Prescription Drug Card Program, and use either a participating pharmacy or the "mail order option." Filling a 90-day supply on maintenance medications using mail order or when using any local Network Pharmacy can reduce the amount of co-payments you pay. Certain *drugs* are not covered, even when prescribed by your *physician*. Please refer to the list of "Excluded *Drugs*" in this section.

### **Covered Prescriptions**

Under the Prescription Drug Card Program, covered expenses include:

- Federal legend drugs.
- State-restricted drugs.
- Insulin, injectable and oral are covered at 100%.
- Syringes and needles used only to inject insulin are covered at 100%.
- Diabetic testing supplies are covered at 100%
- Oral contraceptives.
- Fertility medications.

Certain drugs are not covered, even when prescribed by your physician. Please refer to the list of "Excluded *Drugs*" below.

### **How the Program Works**

There are two ways to purchase drugs through the Plan's Prescription Drug Card Program. You may save money by using the "mail order option" if you have prescription drug(s) that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "pharmacy option"), simply present your Plan ID card and pay your portion of the cost (shown in the "Schedule of Benefits"). The pharmacist will file the claim for you.
- To fill a prescription through the Drug Card Program's "mail order option":
  - Obtain a copy of the mail order form from Security Administrative Services.
  - Complete the patient profile questionnaire (for your first order only).
  - Ask your physician to prescribe the needed medication for a 90-day supply, plus refills.
  - If you are presently taking medication, you will need a new prescription.
  - If you need the medication immediately, **but will be taking it on an on-going basis**, ask your physician for two prescriptions: one for a 14-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the "mail order option."

## **PRESCRIPTION DRUG COVERAGE (CONTINUED)**

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- Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the "Schedule of Benefits").

**Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.**

Copayments for the Prescription Drug Card Program do not accumulate toward the out-of-pocket expense limit.

### **Excluded Drugs**

The Plan will not cover the following drugs, even when prescribed by the covered person's physician:

- **Anorexiant**s (weight control drugs).
- **Experimental or investigational drugs**, including compounded medications for non-FDA-approved use.
- **Dental Prescriptions**.
- **Drugs which are not medically necessary for the treatment of an illness, injury or pregnancy.**
- **Fluoride**.
- **Non-legend drugs**, except as specifically allowed in the plan formulary.
- **Provided in or through a Physician's office** (drugs intended for use in a setting other than the physician's office).
- **Retin A**.
- **Sexual dysfunction drugs**
- **Therapeutic devices** or appliances, support garments, and other non-medical substances.
- **Vitamins**, except prenatal.
- **Workers' Compensation:** prescriptions which an eligible person is entitled to receive, without charge.

## **TERMINATION OF COVERAGE**

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### **When does my participation end?**

Your participation will end at 12:01 A.M. on the earliest of the following dates:

- The date the Plan terminates;
- The last day of the month on which a modification of the Plan terminates coverage for the class of employees or dependents to which the employee or dependent belongs;
- The date on which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The last day of the month following the date of termination of the employee's employment;
- The last day of the month in which you cease to be eligible for coverage under the Plan;
  - The date on which any extension of coverage (including a leave of absence) expires;
  - For any extension of coverage (including a leave of absence) which runs concurrently with COBRA, coverage will end on the date of the extension of coverage (including a leave of absence) begins;
- The last day of the month following the date the employee or dependent spouse ceases to be in a class eligible for coverage;
- The date on which a covered person enters service in the Uniformed Services on an active duty basis, other than for scheduled drills or other training of less than 31 days, unless coverage continuation has been elected under the Uniformed Services Continuation and Reinstatement; or
- The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

### **When does participation end for my dependents?**

The coverage for your dependents will end at 12:01 A.M. on the earliest of the following dates:

- The date the Plan terminates;
- The last day of the month in which the Plan discontinues coverage for dependents;
- The date your dependent becomes covered as an employee under the Plan;
- The last day of the month in which your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your dependents;
- In the case of a child for whom coverage is being continued due to mental or physical inability

## **TERMINATION OF COVERAGE (CONTINUED)**

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to earn his own living, the last day of the month in which earliest of the following events occurs:

- Cessation of the inability;
- Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
- The last day of the month in which dependent reaches age 26;
- The last day of the month in which person ceases to be a dependent; or
- The date the dependent enters full-time military, naval or air service;
- The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

### **Extension of Coverage Provisions**

#### **Approved Leave of Absence**

If a personal or medical leave of absence is approved by the employer, coverage may continue during the leave of absence to a maximum of 90 days from the date on which the leave began, provided the employee bears the full cost of premiums and pays according to the required schedules. This coverage does not run concurrent with COBRA continuation coverage. If the employee does not return to full-time employment within 90 days following the date on which the leave began or upon expiration of the approved leave, whichever is earlier, coverage under the Plan will terminate. The employee may be eligible to continue coverage through COBRA continuation coverage.

#### **Layoff**

If an employee is laid off by the employer, coverage may continue during the layoff to a maximum of 90 days from the date on which the layoff began, provided the employee bears the full cost of premiums and pays according to the required schedules. This coverage does not run concurrent with COBRA continuation coverage. If the employee does not return to full-time employment within 90 days following the date on which the layoff began or upon expiration of the layoff, whichever is earlier, coverage under the Plan will terminate. The employee may be eligible to continue coverage through COBRA continuation coverage.

#### **Retired Employee Coverage Continuation**

A covered employee who retires from employment with the employer and meets the age and service requirements as specified in the Clark County Personnel Policy may continue coverage under the Plan. Election to continue coverage under the Plan must be made prior to the date of retirement. The continued coverage will become effective on the date following the expiration of the active employee's, employee and/or employer, contribution sponsored coverage. The employee may continue coverage under the Plan until death. The employee's spouse may also continue coverage under the Plan until the earlier of:

- a) The date the spouse remarries; or
- b) The date the spouse dies. A dependent child may remain covered under the Plan provided the dependent meets the eligibility requirements of the Plan.

## **TERMINATION OF COVERAGE (CONTINUED)**

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### **Severance Continuation**

If a covered employee's employment with the employer is terminated, and if a written severance agreement executed by the employer and employer provides such employee with coverage under the Plan after termination of employment, then such coverage shall continue for the period specified in the written severance agreement. However, in no event shall coverage extend for a period of more than 365 days from the date on which the employee terminated employment with the employer. The extension of coverage provided in this severance provision will run concurrently with the COBRA continuation coverage provision and upon the expiration of the severance extension of coverage the remaining period of COBRA continuation period may continue in accordance with COBRA rules.

### **Continuation During FMLA Leave**

Regardless of the established policies mentioned [above], the Plan will at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

To continue coverage, the Employee must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay his or her contributions, if any. Contact your participating Employer for information concerning Employee eligibility for FMLA and any requirements of the Plan.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the Plan changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for COBRA continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

### **Recovery of Plan Contributions During FMLA**

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

### **Reinstatement of Coverage After FMLA**

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

FMLA does not affect any Federal or State Law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. In addition to FMLA leave, you may also be eligible for leave under a similar state law. Please contact Clark County Office of Personnel.

## **TERMINATION OF COVERAGE (CONTINUED)**

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### **May I continue participation while I am absent under USERRA?**

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your dependents, where:

1. They were covered persons in the Plan immediately prior to your leave of absence for uniformed service; and
2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your participating employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;
2. The cumulative length of this absence and all previous absences with your participating employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and
3. You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your participating employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

### **What is the cost of continuing coverage under USERRA?**

The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your participating employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

### **When will coverage continued through USERRA terminate?**

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

1. The date you fail to apply for, or return to, work for your participating employer following completion of your leave. You must notify your participating employer of your intent to return to employment within:
  - a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the participating employer (i) not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence, or (ii) if reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible

## **TERMINATION OF COVERAGE (CONTINUED)**

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after the expiration of the eight-hour period referred to in (i).

- b. For leaves of 30 to 180 days, by reporting to the participating employer (i) not later than 14 days after completing uniformed service, or (ii) if reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the period referred to in (i).
- c. For leaves of more than 180 days, by submitting an application for reemployment with your participating employer not later than 90 days after completing uniformed service.
- d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your participating employer at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your participating employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances; or
- e. 24 months from the date your leave began.

Continued coverage provided under this provision will **not** reduce the maximum period allowed for continuation provided under COBRA.

### **How will my coverage be reinstated on return from USERRA leave?**

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your participating employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your participating employer.

### **How do we continue our coverage under COBRA?**

A federal law known as COBRA gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your participating employer to see if COBRA applies to you and your dependents.

Any COBRA continuation option may include the benefits for which the "qualified beneficiary" was covered just prior to the COBRA "qualifying event" (an event which qualifies a person for continued coverage under COBRA). Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your participating employer's plan) are not

## **TERMINATION OF COVERAGE (CONTINUED)**

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considered for continuation under COBRA.

Continuation will be available up to the maximum time period shown below. Multiple qualifying events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original qualifying event. When the qualifying event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original event. For all other qualifying events, the continuation period is measured from the date of the qualifying event, not the date of loss of coverage.

The maximum time period for continued coverage will be the earliest of the following:

- Up to 18 months for you and your covered dependents when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

Note: If you are disabled on the date of the qualifying event, you may have COBRA coverage extended (and an extra fee charged) from 18 months to 29 months provided that:

- You are disabled for Social Security purposes during the first 60 days of COBRA coverage; and
- You notify the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month COBRA period.
- Up to 36 months for:
  - A dependent child who is a covered person in the Plan and who ceases to be an eligible dependent;
  - A dependent who is a covered person in the Plan and whose eligibility ceases due to your death;
  - A spouse who is a covered person in the Plan and whose eligibility ceases due to divorce or legal separation; or
  - A dependent who is a covered person in the Plan, when your coverage ceases due to entitlement to Medicare.
- Under COBRA's special bankruptcy rules for retirees and their dependents who are covered persons, continuation coverage following the qualifying event of the participating employer's filing for reorganization under the Bankruptcy Code must extend until:
  - Your date of death or your surviving spouses date of death, if your death happens before the filing and your spouse still had coverage under the Plan; or
  - 36 months after your date of death, in the case of your surviving spouse or dependent child.

Continued coverage may also end before the end of the maximum period on the earliest of the following dates:

- The date your participating employer ceases to provide a group health plan to any employee;

## **TERMINATION OF COVERAGE (CONTINUED)**

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- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium;
- The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first; or
- The first day of the month that begins more than 30 days after the date of the Social Security Administration's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

In the event of divorce, legal separation or change of dependent status, you have 60 days from the qualifying event in which to notify the Plan Administrator that the qualifying event has occurred. With respect to qualified beneficiaries who are disabled, in the event the Social Security Administration issues a final determination that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator of this determination within 30 days of the date it is made. Complete instructions on how to elect continuation coverage will be provided by the Plan Administrator within 14 days of receiving your notice. You then have 60 days in which to elect continuation.

The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

Once coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, coverage will be canceled and will not be reinstated.

### **Is it possible to have more than one qualifying event?**

A second qualifying event could occur during the initial period of COBRA coverage due to the death of the former employee, or the spouse if he or she elected separately and covered eligible dependents, divorce, or other loss of eligibility such as a dependent reaching the limiting age. When such a qualifying event occurs, the requirements specified for notice and election and premium payments will apply. The maximum time period for continuation following the second qualifying event will be combined with the preceding period of coverage under COBRA so that the total period of coverage will not exceed 36 months.

### **Additional Information**

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is:

Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
(800) 570-8760

### **Current Addresses**

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

## **CLAIM PROCEDURES**

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You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

**Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
800-570-8760**

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including PPO network repricing information);
- The name of the Plan;
- The name of the covered employee; and
- The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

### **Procedures For All Claims**

The procedures outlined below must be followed by covered persons to obtain payment of health benefits under this Plan.

### **Health Claims**

All claims and questions regarding health claims should be directed to the third party administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the covered person is entitled to them. The responsibility to process claims in accordance with the summary plan description may be delegated to the third party administrator; provided, however, that

## **CLAIM PROCEDURES (CONTINUED)**

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the third party administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each covered person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the covered person has not incurred a covered expense or that the benefit is not covered under the Plan, or if the covered person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service, Urgent, Concurrent Care and Post-service.

- **Pre-service claim** – a claim for a benefit under the plan with respect to which the terms of the plan require approval of the benefit in advance of obtaining medical care.
- **Urgent care claim** – any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of the covered person or subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.
- **Concurrent care claim** – a claim for an extension of the duration or number of treatments provided through a previously approved claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- **Post-service care claim** – a claim for payment or reimbursement after services have been rendered.

Pre-service care, urgent care and concurrent care claims may also be described as requests for coverage or requests for authorization of benefits. These terms may be used interchangeably in the Summary Plan Document and in the administration of your coverage.

### **When Health Claims Must Be Filed**

The covered person or the health care provider on the covered person's behalf, must submit to the third party administrator written proof of your claim for each service within 180 days of the date on which you receive that service. Written proof of your claim includes:

- The completed claim forms if required by us;
- The actual itemized bill for each service; and
- All other information that the third party administrator needs to determine the liability to pay benefits under the plan, including, but not limited to, medical records and reports.

If circumstances beyond the covered person's control prevent submission such proof to us within this time period, we will accept a proof of claim, if provided as soon as possible and within fifteen months. If we do not receive the written proof of claim required by us within that fifteen month period, no benefits are payable for that service.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. An incomplete claim is a correctly filed claim that requires additional information, including but not

## **CLAIM PROCEDURES (CONTINUED)**

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limited to, medical information, coordination of benefits questionnaire, or a subrogation questionnaire. An incorrectly filed claim is one that lacks information which enables the third party administrator to determine what, if any, benefits are payable under the terms and conditions of the plan. Examples include, but are not limited to, claims filed that are missing procedure codes, diagnosis information or dates of service. This additional information must be received by the third party administrator within 45 days from receipt by the covered person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

### **Timing of Claim Decisions**

The Plan Administrator shall notify the covered person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- **Urgent care claims.** If the covered person's claim involves urgent care, the covered person or their authorized representative will be notified the initial decision on the claim as soon as is feasible, but in no event more than 24 hours after receiving the claim. If the claim does not include sufficient information for the third party administrator to make a decision, the covered person or representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. The covered person will have at least 48 hours to respond to this request; the third party administrator then must inform the covered person of the decision within 48 hours of receiving the additional information.
- **Concurrent care claims.** If the claim is one involving concurrent care, third party administrator will notify covered person of decision within 24 hours after receiving the claim, if the claim was for urgent care and was received by the third party administrator at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. Covered person will be given time to provide any additional information required to reach a decision. If the concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, third party administrator will respond according to the type of claim involved (i.e., urgent, pre-service or post-service).
- **Pre-service claims.** A pre-service claim is any claim for a benefit under the plan which requires prior approval or precertification before obtaining medical care. If the claim is for pre-service authorization, the third party administrator will notify you of the initial determination as soon as possible, but not more than 15 days from the date the claim is received. This 15-day period may be extended by the third party administrator for an additional 15 days if the extension is required due to matters beyond our control. The covered person will have at least 45 days to provide any additional information requested.

If covered person fails to follow the Plan's procedures for filing a pre-service claim, the covered person or authorized representative shall be notified orally or in writing not later than 5 days (24 hours in the case of urgent care) following the failure. This notice, however, applies only when you submit a claim to the appropriate claims unit with the requested identifying claim information.

- **Post-service claim.** If claim is for a post-service reimbursement or payment of benefits, third party administrator will notify you within 30 days of receipt of the claim if the claim has been denied or if further information is required. The 30 days can be extended to 45 if third party administrator notifies the covered person within the initial 30 days of the circumstances beyond our control that require an extension of the time period, and the date by which a decision is expected.

## **CLAIM PROCEDURES (CONTINUED)**

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If more information is necessary to decide a post-service claim, third party administrator will notify you of the specific information necessary to complete the claim. Covered person will be given at least 45 days from the receipt of the notice to provide the necessary information.

### **Notification of an Adverse Benefit Determination**

If benefits are payable, the Plan will pay them as soon as reasonably possible directly to the hospital, physician or other health care provider providing such services. If, for any reason, an adverse benefit determination is received, in whole or in part, covered person will be provided with a written notice containing the following information:

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the covered person's right to bring a civil action under applicable state law following an adverse benefit determination on final review;
- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the covered person's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the covered person, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, or a statement that such explanation will be provided to the covered person, free of charge, upon request.
  - Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
    - Notification to Participant 30 days
    - Notification of Adverse Benefit Determination on appeal 30 days

**Appeal of Adverse Benefit Determinations**

**Full and Fair Review of All Adverse Benefit Determinations**

In cases where a claim for benefits is denied, in whole or in part, and the covered person may dispute an adverse benefit determination. The covered person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. The Plan will continue coverage pending the outcome of the appeal you file using this process. More specifically, the Plan provides:

- Covered person opportunity to file a formal appeal, write down your concerns and mail or deliver your written grievance (in any form) along with copies of any supporting documents to third party administrator at least 180 days following receipt of a notification of an initial adverse benefit determination.
- Third party administrator will acknowledge your written request for an appeal within five working days of receiving it.
- Covered person may designate a representative to act on your behalf by sending an appropriately worded authorization along with the appeal. The written designation of a representative is necessary to protect against disclosure of information about you except to the authorized representative.
- The written appeal along with any supportive information will be forwarded to the Appeal Committee for a prompt and thorough investigation. You have a right to appear before the Appeal Committee to present written or oral information and question the people responsible for making the determination that resulted in the appeal.
- Within 30 days after receipt of the written appeal, the Committee will send you its written decision which will contain the specific reasons for the decision, identify the specific plan provisions, if any, on which the decision is made, and what corrective action, if any, has been taken.
- In some situations the Committee may need additional time to make a decision. In that case, before the 30-day period has expired, the Committee will send a written notice that more time is necessary, how much more time, and the reason more time is needed. Then the Committee has an additional 21 days after the first 30-day period has expired to provide you with its written decision.
- In connection with your right to appeal the adverse benefit determination, you may review pertinent documents and submit issues and comments in writing; covered person will be given the opportunity to submit written comments, documents, records, or any other matter relevant to the claim; will, at request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and be given a review that takes into account all comments, documents, records, and other information submitted by the covered person relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.
- The claim will be reviewed by an appropriate named fiduciary, who is neither the individual who made the initial denial nor a subordinate of that individual. The review will be conducted without giving deference to the initial denial. If the initial denial was based in whole or in part on a medical judgment (including any determinations of medical necessity or experimental/investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical

## **CLAIM PROCEDURES (CONTINUED)**

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judgment. This health care professional shall not be an individual who was consulted on the initial claim nor the subordinate of such an individual. Upon request, we will identify by name any medical or vocational experts consulted in the review process. The review will consider all information submitted, regardless of whether it was considered during the initial determination.

### **First Level Appeal**

#### **Requirements for First Appeal**

The covered person must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the covered person's appeal must be addressed as follows and mailed or faxed as follows:

**Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449  
800-570-8760**

It shall be the responsibility of the covered person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the covered person;
- The covered person's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the covered person will lose the right to raise factual arguments and theories which support this claim if the covered person fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the covered person has which indicates that the covered person is entitled to benefits under the Plan.

#### **Timing of Notification of Adverse Benefit Determinations on Review**

The Plan Administrator shall notify the covered person of the Plan's benefit determination on review within the following timeframes:

- Urgent care claims – not later than 72 hours after receiving your request for a review.
- Pre-service claims – not later than 15 days after receiving your request for a review.
- Post-service claims – not later than 30 days after receiving your request for a review.
- Concurrent claims - decisions will be issued within the timeframe appropriate for the type of concurrent care claim (i.e., urgent, pre-service or post-service).

## **CLAIM PROCEDURES (CONTINUED)**

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- **Calculating Time Periods.** The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

### **Manner and Content of Notification of Adverse Benefit Determination on Review**

The Plan Administrator shall provide a covered person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;

### **Reference to the specific portion(s) of the summary plan description on which the denial is based;**

### **The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;**

- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, will be provided free of charge upon request;
- A description of available external review processes;
- A statement of the covered person's right to bring a civil action under applicable state law following an adverse benefit determination on final review; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

### **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

### **Timing of Notification of Adverse Benefit Determinations on Review**

The Plan Administrator shall notify the covered person of the Plan's benefit determination on review within the following timeframes:

- **Urgent care claims** – not later than 72 hours after receiving your request for a second review.
- **Pre-service claims** – not later than 15 days after receiving your request for a second review.

## CLAIM PROCEDURES (CONTINUED)

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- Post-service claims – not later than 30 days after receiving your request for a second review.
- Concurrent claims – decisions will be issued within the timeframe appropriate for the type of concurrent care claim (i.e., urgent, pre-service or post-service).
- Calculating Time Periods – The period of time within which the Plan’s determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

### **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

### **Decision on Review to be Final**

If, for any reason, the covered person does not receive a written response to the appeal within the appropriate time period set forth above, the covered person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. Covered person may not begin any legal action, including proceedings before administrative agencies, until you have followed the appeal procedures and exhausted the opportunities described in this section. However, if the third party administrator fails to strictly adhere to all the procedures in this section, then the covered person will be deemed to have followed these procedures. The covered person may, at your own expense, have legal representation at any stage of these review procedures. These appeal procedures shall be the only means through which an adverse benefit determination may be appealed. **All adverse benefit determination review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 180 days after the Plan’s adverse benefit determination review procedures have been exhausted.**

### **External Review Process**

#### **Scope**

- The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.
- The Federal external review process applies only to:
  - An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
  - A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

**Standard External Review**

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

- **Request for external review.** The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
  - The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
  - The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
  - The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
  - The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

- **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial

## **CLAIM PROCEDURES (CONTINUED)**

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incentives based on the likelihood that the IRO will support the denial of benefits.

- **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

### **Expedited External Review**

- **Request for expedited external review.** The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
  - An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
  - A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
- **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
- **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

- **Notice of final external review decision.** The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is

## **CLAIM PROCEDURES (CONTINUED)**

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not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

### **Appointment of Authorized Representative**

A covered person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a covered person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the covered person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the covered person's medical condition to act as the covered person's authorized representative without completion of this form. In the event a covered person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the covered person, unless the covered person directs the Plan Administrator, in writing, to the contrary.

### **Physical Examinations**

The Plan reserves the right to have a physician of its own choosing examine any covered person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The covered person must comply with this requirement as a necessary condition to coverage.

### **Autopsy**

The Plan reserves the right to have an autopsy performed upon any deceased covered person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

### **Payment of Benefits**

All benefits under this Plan are payable, in U.S. Dollars, to the covered employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee.

### **Assignments**

Benefits for medical expenses covered under this Plan may be assigned by a covered person to the provider; however, if those benefits are paid directly to the employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

No covered person shall at any time, either during the time in which he is a covered person in the Plan, or following his termination as a covered person, in any manner, have any right to assign his right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he may have against the Plan or its fiduciaries.

### **Non-U.S. Providers**

Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. provider;

## **CLAIM PROCEDURES (CONTINUED)**

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- The covered person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

### **Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person or dependent on whose behalf such payment was made.

A covered person, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a covered person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9/ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a covered person, provider or other person or entity to enforce the provisions of this section, then that covered person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

### **Medicaid Coverage**

A covered person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such covered person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the covered person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

## **COORDINATION OF BENEFITS**

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### **Benefits Subject to This Provision**

This provision applies to all benefits provided under any section of this Plan.

### **“Other Plan”**

“Other plan” means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- Group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, and other group prepayment coverage;
- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

### **“Allowable Expenses”**

“Allowable expenses” shall mean any medically necessary, usual, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of other plan(s) for payment of benefits. If you fail to properly file for, and receive payment by, any other plan(s), this Plan will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the “Application to Benefit Determination” calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the covered person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the covered person used the services of an HMO provider.

### **Effect on Benefits**

#### **Application to Benefit Determinations**

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. If this Plan is a secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative allowable expenses for that calendar year; however, in no event will this Plan pay more than it would have in the absence of any other plan(s). When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

When medical payments are available under automobile insurance, this Plan will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

## **CLAIM PROCEDURES (CONTINUED)**

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In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

- The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
- The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

### **Order of Benefit Determination**

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

- A plan without a coordinating provision will always be the primary plan;
- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent;
- If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
  - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
  - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

**Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child;**

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

### **Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

## **CLAIM PROCEDURES (CONTINUED)**

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### **Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

### **Right of Recovery**

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

### **Coordination of Benefits with Medicare**

If you are actively working, are eligible for Medicare, and you are eligible for coverage under this Plan, you may choose to continue coverage under this Plan, and any Medicare benefits to which you are entitled may be used to supplement the benefits of this Plan. If, however, you choose to make Medicare your primary plan, you may not supplement your Medicare coverage with the benefits of this Plan.

If you are retired and covered by this Plan, it is secondary to Medicare and will pay all amounts which are covered under the terms of this Plan which are not contractual reductions under Medicare. This means this Plan will cover you Medicare deductibles and coinsurance for covered benefits under the Plan.

In all cases, coordination of benefits with Medicare will conform with Federal law. When coordination of benefits with Medicare is permitted, each individual who is eligible for Medicare will be assumed to have full Medicare coverage whether or not the individual has enrolled for full coverage. Your benefits under this Plan will be coordinated to the extent allowed by Federal law.

### **Coordination of Benefits with Medicaid**

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

## **SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT**

### **Benefits Subject to this Provision**

This provision shall apply to all benefits provided under any section of this Plan.

### **When this Provision Applies**

A covered person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the covered person may have a claim against that other person or another party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the covered person may have against that other person or another party and will be entitled to reimbursement. In addition, the Plan shall have the first lien against any recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the covered person may have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any recovery the covered person procures or may be entitled to procure regardless of whether the covered person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the covered person agrees that acceptance of benefits is constructive notice of this provision.

The covered person must:

- Execute and deliver a subrogation and reimbursement agreement;
- Authorize the Plan to sue, compromise and settle in the covered person's name to the extent of the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the covered person's rights to recovery when this provision applies;
- Immediately reimburse the Plan, out of any recovery made from another party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
- Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

**When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the covered person will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of subrogation and reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness.** The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injuries or illness before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the Plan still will be entitled to subrogation and reimbursement.

## **SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (CONTINUED)**

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In addition, the covered person will do nothing to prejudice the Plan's right to subrogation and reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A covered person who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the covered person is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

### **Amount Subject to Subrogation or Reimbursement**

Any amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the covered person does not receive full compensation for all of his charges and expenses.

### **When Recovery Includes the Cost of Past or Future Expenses**

In certain circumstances, a covered person may receive a recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the recovery. This Plan will not cover any expenses for which compensation was provided through a previous recovery. This exclusion will apply to the full extent of such recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the covered person to inform the Plan Administrator when expenses are related to an illness or injury for which a recovery has been made. Acceptance of benefits under this Plan for which the covered person has received a recovery will be considered fraud, and the covered person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The covered person is required to submit full and complete documentation of any such recovery in order for the Plan to consider eligible expenses that exceed the recovery.

### **"Another Party"**

"Another party" shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a covered person's injuries or illness.

"Another party" shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a covered person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the injuries or illness.

### **"Recovery"**

"Recovery" shall mean any and all monies paid to the covered person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any recovery shall be deemed to apply, first, for reimbursement.

## **SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (CONTINUED)**

### **"Subrogation"**

"Subrogation" shall mean the Plan's right to pursue the covered person's claims for medical or other charges paid by the Plan against another party.

### **"Reimbursement"**

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

### **When a Covered Person retains an Attorney**

If the covered person retains an attorney, that attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the covered person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of recovery. The Plan will not pay the covered person's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the covered person's attorneys' fees and costs. Attorneys' fees will be payable from the recovery only after the Plan has received full reimbursement.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the covered person nor his attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

### **When the Covered Person is a Minor or is Deceased**

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor covered person and to the heir or personal representative of the estate of a deceased covered person, regardless of applicable law and whether or not the representative has access or control of the recovery.

### **Separation of Funds**

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement..

### **When a Covered Person Does Not Comply**

When a covered person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement. If the Plan must bring an action against a covered person to enforce the provisions of this section, then that covered person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

## **DEFINITIONS**

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In this section you will find definitions for words found throughout this summary plan description. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

**"Accident"** means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

**"Actively at work" or "Active employment"** means performance by the employee of all the regular duties of his occupation at an established business location of the participating employer, or at another location to which he may be required to travel to perform the duties of his employment. An employee will be deemed actively at work if the employee is absent from work due to a health factor. In no event will an employee be considered actively at work if he has effectively terminated employment.

**"Adoption" or "Placement for Adoption"** means a child who has not attained 18 years of age and is adopted or placed for adoption pursuant to the following Wisconsin Statutes:

- the department, a county department under s. 48.57 (1) (e) or (hm) or a child welfare agency licensed under s. 48.60 places a child in the covered employee's home for adoption and enters into an agreement under s. 48.833 with the covered employee;
- a court under s. 48.837 (6) (b) orders a child placed in the covered employee's home for adoption;
- a sending agency, as defined in s. 48.988 (2) (d), places a child in the covered employee's home under s. 48.988 for adoption, and the covered employee takes physical custody of the child at any location within the United States;
- the person bringing the child into this state has complied with s. 48.98, and the covered employee takes physical custody of the child at any location within the United States; or
- a court of a foreign jurisdiction appoints the covered employee as guardian of a child who is a citizen of the jurisdiction, and the child arrives in the covered employee's home for the purpose of adoption by the covered employee under s. 48.839

**"Adverse Benefit Determination"** means any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

**"AMA"** means the American Medical Association.

**"Ambulatory surgical center"** means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of physicians, with permanent facilities

## **DEFINITIONS (CONTINUED)**

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that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing service whenever a patient is in the institution, and which does not provide service or other accommodations for patients to stay overnight.

**"Brand name drug"** means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

**"Cardiac care unit"** means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

**"Certificate of coverage"** means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

**"Child(ren)"** means, in addition to the employee's own blood descendant of the first degree or lawfully adopted child, any stepchild, a child placed with the employee in anticipation of adoption, a child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, a grandchild of a covered dependent child under the age of 18, or any other child for whom the employee has obtained legal guardianship and who resides with and who is dependent upon the employee in a regular parent-child relationship.

**"CHIP"** (also called "SCHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section may be amended from time to time.

**"Chiropractic care"** means office visits, X-rays, manipulations, supplies, heat treatment, cold treatment and massages

**"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**"Cochlear implant"** includes any implantable instrument or device that is designed to enhance hearing.

**"Co-insurance"** The specified amount you are required to pay for certain medical care after you have met your deductible (if applicable). The coinsurance rate is usually expressed as a percentage. For example, if a plan pays 80 percent of the claim, you pay 20 percent.

**"Company"** means Clark County Insurance Claims

**"Cosmetic" or "cosmetic surgery"** means any surgery, service, drug or supply designed to improve the

## **DEFINITIONS (CONTINUED)**

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appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an injury.

**“Covered expense”** means a medically necessary service or supply which is usual, customary and reasonable, and which is listed for coverage in this Plan.

**“Covered person”** means a covered employee and his covered dependents, who are eligible for benefits under the Plan.

**“Creditable coverage”** means prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

**“Custodial care”** means care or confinement provided primarily for the maintenance of the covered person, essentially designed to assist the covered person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

**“Deductible”** means an amount of money that must be paid by a covered person for covered expenses before the Plan will reimburse additional covered expenses incurred during that plan year.

**“Dependent”** means one or more of the following person(s):

- An Employee’s lawful spouse in the state of residence, living in the same country, if not legally separated or divorced. The Plan Administrator may require documentation proving a legal marital relationship. This includes same sex spouses where a same sex marital relationship is recognized as legal under applicable state law or federal law.

Not considered eligible for spousal coverage:

- Common Law Spouses; and
  - Domestic partnerships; or
  - If a divorce is pending, a Spouse cannot be dropped from coverage until the divorce is finalized. A finalized divorce decree must be submitted in order to drop Spouse’s coverage from this Plan.
- An employee’s child who is less than age of 26 or;
  - A grandchild, as long as the employee’s covered dependent, who is the parent of the grandchild, is not yet age 18.
  - An employee’s child who was continuously covered prior to attaining the limiting age above, who is mentally or physically incapable of sustaining his own living and is still primarily

## **DEFINITIONS (CONTINUED)**

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dependent upon the employee for support. Such child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the third and fourth bullets above. You must furnish satisfactory proof to the Plan Supervisor that the above conditions continuously exist on and after the date the limiting age is reached. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a dependent relationship.

“**Diagnostic service**” means a test or procedure performed for specified symptoms to detect or to monitor an illness or injury. It must be ordered by a physician or other professional provider.

“**Drug**” means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed physician.

“**Durable medical equipment**” means equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

“**Emergency**” means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, and unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an emergency did exist.

“**Employee**” means a person who is a regular full-time or part-time employee of the participating employer, regularly scheduled to work for the participating employer in an employer-employee relationship. Such person must be scheduled to work at least 80 hours per month in order to be considered “full-time.” An employee is not a temporary, seasonal or leased employee.

“**Experimental or Investigational**” means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug

## **DEFINITIONS (CONTINUED)**

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Administration and the AMA's Council on Medical Specialty Societies. All phases of clinical trials shall be considered experimental.

Drugs are considered experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Coverage for routine health care costs incurred in conjunction with a clinical trial will be covered in accordance with the terms of Wisconsin Statutes 632.855 (3)(bm) and 632.87 (6) and the Patient Protection and Affordable Care Act. The following criteria is used to determine if performed or used on a widespread geographic basis;

- whether the service is commonly performed or used on a widespread geographic basis;
- whether it is generally accepted to treat that illness or injury by the medical profession in the United States;
- its failure rate and side effects;
- whether other, more conventional methods of treating the illness or injury have been exhausted by the participant;
- whether it is medically indicated; and
- whether it is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

To question whether a particular service is considered experimental or investigative, please contact us at 1-800-991-8109. The Office of the Medical Director, utilizing the Technology Assessment Process as necessary, makes the decision as to whether a procedure is experimental or investigative. That decision may be appealed to through the appeals process outlined in the "Claims Procedures" section. If an urgent care need exists, the urgent care appeal procedure will be followed.

**"Family unit"** means the employee, his spouse and his dependent children.

**"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process applicable or an Adverse Benefit Determination with respect to which the internal appeals process has been deemed exhausted for the Plan's failure to follow the appeals procedures.

**"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

**"FMLA leave"** means a leave of absence, which the company is required to extend to an employee under the provisions of the FMLA.

**"GINA"** means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information

**"Generic drug"** means drugs not protected by a trademark, usually descriptive of drug's chemical structure. **"Health Breach Notification Rule"** means **16 CFR Part 318**.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

## **DEFINITIONS (CONTINUED)**

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**"Home Health Aide Services"** means those services which may be provided by a qualified individual, other than a registered nurse, which are medically necessary for the care and treatment of a covered person.

**"Home health care"** means certain services and supplies required for treatment of an illness or injury in the covered person's home as part of a formal treatment plan certified by the attending physician and approved by the Plan Administrator.

**"Home health care agency"** means an agency or organization which provides a program of home health care and which:

- Is approved as a home health agency under Medicare;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
  - It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
  - Its employees are bonded and it provides malpractice insurance.

**"Hospice Care Agency"** means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a Qualified Practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;
- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an on going quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

## **DEFINITIONS (CONTINUED)**

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**"Hospital"** means an institution that meets all of the following requirements:

- It provides medical and surgical facilities for the treatment and care of injured or sick persons on an inpatient basis;
- It is under the supervision of a staff of physicians;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported institution;
- A hospital also includes a specialty hospital approved by the *Third Party Administrator* and is licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have a specified medical condition.
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and

**"Illness"** means a condition, pregnancy, sickness or disease not resulting from trauma.

**"Immediate relative"** means spouse, child, brother, sister or parent of the covered person, whether by birth, adoption or marriage

**"Impregnation and infertility treatment"** means artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

**"Incurred"** means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

**"Injury"** means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an accident.

**"Independent Review Organization"** or **"IRO"** means an entity that conducts independent external review of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations and that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.

**"Inpatient"** means any person who, while confined to a hospital, is assigned to a bed in any department of the hospital other than its outpatient department and for whom a charge for room and board is made by the hospital.

**"Institution"** means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a hospital, ambulatory surgical center, psychiatric hospital, community mental health center, residential treatment facility, psychiatric hospital, substance abuse treatment center, alternative birthing center, home health care center, or any other such facility that the Plan approves.

## **DEFINITIONS (CONTINUED)**

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**"Intensive care unit"** means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

**"Leave of absence"** means a leave of absence of an employee that has been approved by his participating employer, as provided for in the participating employer's rules, policies, procedures and practices.

**"Legal separation"** means a court-decreed right to live apart, with the rights and obligations of divorced persons, but without divorce. The parties are still married and cannot remarry. A spouse may petition for a legal separation usually on the same basis as for a divorce, and include requests for child custody, alimony, child support and division of property.

**"Mastectomy"** means the surgical removal of all or part of a breast.

**"Medically necessary"** means services or supplies which are determined by the Plan Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, injury or illness;
- Provided for the diagnosis or direct care and treatment of the medical condition, injury or illness;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the covered person, the covered person's physician or another provider; and
- The most appropriate supply or level of service which can safely be provided.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the covered person is receiving or the severity of the covered person's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

**"Medicare"** means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

## **DEFINITIONS (CONTINUED)**

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**"Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")"** means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

**"Mental or nervous disorder"** means any illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**"Morbid obesity"** means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the covered person.

**"Network"** means the Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to covered persons. The network will be identified on the covered person's Plan Identification Card.

**"Out-of-pocket expense"** means the cost to the covered person for deductibles, coinsurance, copayments, penalties and non-covered expenses.

**"Participating employer(s)"** means Clark County Insurance Claims

**"Physician"** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

**"Plan"** means the Clark County Insurance Claims Employee Welfare Benefit Plan.

**"Plan Effective date"** means, January 1 1997, the original effective date of the Plan.

**"Plan Administrator"** means Clark County Insurance Claims.

**"Plan Document"** means this Plan Document and Summary Plan Description.

**"Plan Sponsor"** means Clark County Insurance Claims.

**"Plan year"** means the period commencing January and continuing until the next succeeding anniversary.

## **DEFINITIONS (CONTINUED)**

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**"Pre-admission tests"** means those diagnostic services done before a scheduled hospital inpatient admission provided that:

- The tests are required by the hospital and approved by the physician;
- The tests are performed on an outpatient basis prior to hospital admission;
- The tests are not duplicated on admission to the hospital; and
- The tests are performed at the hospital where the confinement is scheduled, or at a qualified facility approved by the hospital to perform the tests.

**"Preferred Provider Organization" or "PPO"** means the network of providers offering discounted fees for services and supplies to covered persons. The network will be identified on the covered person's Plan Identification Card.

**"Pregnancy"** means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers pregnancy as an illness for the purpose of determining benefits.

**"Preventive Care"** means certain preventive care services.

This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

**"Privacy Standards"** means the standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

**"Provider"** means a physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, licensed physician's assistant, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

## **DEFINITIONS (CONTINUED)**

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**"Psychiatric hospital"** means an institution constituted, licensed, and operated as set forth in the laws that apply to hospitals, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a physician;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a psychiatric hospital;
- It requires that every patient be under the care of a physician; and
- It provides 24-hour-a-day nursing service.

It does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

**"Reasonable"** means in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

**"Rehabilitation hospital"** means an institution which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or

## **DEFINITIONS (CONTINUED)**

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- It is approved for its stated purpose by Medicare.

**“Room and board”** means an institution’s charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are medically necessary.

**“Significant break in coverage”** means a period of 63 consecutive days during all of which an individual did not have any creditable coverage, but does not include waiting periods and affiliation periods.

**“Substance Abuse”** means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
  - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
  - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
  - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
  - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- The symptoms have never met the criteria for Substance Dependence for this class of substance.

**“Substance abuse treatment center”** means an institution which provides a program for the treatment of substance abuse by means of a written treatment plan approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed, certified or approved as an alcohol or substance abuse treatment program or center by a state agency having legal authority to do so.

## **DEFINITIONS (CONTINUED)**

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**"Summary plan description"** means this Plan Document and Summary Plan Description.

**"Surgery" or "Surgical Procedure"** means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- The induction of artificial pneumothorax and the injection of sclerosing solutions;
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- Obstetrical delivery and dilation and curettage; or
- Biopsy.

**"Third party administrator"** means Security Administrative Services.

**"Trade Act"** means the Trade Act of 2002, as amended.

**"Uniformed services"** means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

**"Usual, customary"**

means covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the

## **DEFINITIONS (CONTINUED)**

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specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

**"Waiting period"** means an interval of time during which the employee is in the continuous, active employment of his participating employer before he becomes eligible to participate in the Plan.

## **PLAN ADMINISTRATION**

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### **Who has the authority to make decisions in connection with the Plan?**

The Plan is administered by the Plan Administrator in accordance with state and federal requirements. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a covered person's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting;
- To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

## **PLAN ADMINISTRATION (CONTINUED)**

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### **May changes be made to the Plan?**

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by applicable state and federal law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

## **MISCELLANEOUS INFORMATION**

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### **Who pays the cost of the Plan?**

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the covered person's contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

### **Will the Plan release my information to anyone?**

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or covered person for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the privacy standards. Any covered person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

### **What if the Plan makes an error?**

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to covered persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

### **Severability**

If any term or provision of this Plan Document and Summary Plan Description is held to be invalid, unlawful or unenforceable for any reason, such invalidity, illegality or unenforceability shall not affect the remain portion of this Plan Document and Summary Plan Description.

## **MISCELLANEOUS INFORMATION (CONTINUED)**

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### **Will the Plan conform with applicable laws?**

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this summary plan description. It is intended that the Plan will conform to the requirements of all applicable law.

### **What constitutes a fraudulent claim?**

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which you are a member:

Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a covered person in the Plan;

Attempting to file a claim for a covered person for services that were not rendered or drugs or other items that were not provided;

- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing any false or misleading information to the Plan.

### **How will this document be interpreted?**

The use of masculine pronouns in this summary plan description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this summary plan description are used for convenience of reference only. Covered persons are advised not to rely on any provision because of the heading. The use of the words, "you" and "your" throughout this summary plan description applies to eligible or covered employees and, where appropriate in context, their covered dependents.

### **How may a Plan provision be waived?**

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

### **Is this summary plan description a contract between the employer and covered persons?**

This summary plan description and any amendments constitute the terms and provisions of coverage under this Plan. The summary plan description shall not be deemed to constitute a contract of any type between the employer and any covered person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this summary plan description shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any employee at any time.

### **What if there is coverage through workers' compensation?**

This Plan excludes coverage for any injury or illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such injury or illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive workers' compensation coverage for the same injury or illness, the Plan is entitled to full recovery for the benefits

## **MISCELLANEOUS INFORMATION (CONTINUED)**

it has paid. This exclusion applies to past and future expenses for the injury or illness regardless of the amount or terms of any settlement you receive from workers' compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

**You are required to notify the Plan Administrator immediately when you file a claim for coverage under workers' compensation if a claim for the same injury or illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.**

### **Will the Plan cover an alternate course of treatment?**

The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

If a covered person, in cooperation with his provider, elect a course of treatment that is deemed by the Plan Administrator, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the illness or injury, this Plan will allow coverage for the usual, customary and reasonable value of the less costly or extensive course of treatment

## **HIPAA PRIVACY PRACTICES**

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

### **Disclosure of Summary Health Information to the Plan Sponsor**

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

## **HIPAA PRIVACY PRACTICES (CONTINUED)**

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### **Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- Comply with all requirements of the Genetic Information Nondiscrimination Act of 2008 including, but no limited to:
  - Prohibiting the use of genetic information in employment decision making.
  - Restricting deliberate acquisition of genetic information.
  - Maintaining genetic information as a confidential medical record.
  - Placing strict limits on the disclosure of genetic information.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

## **HIPAA PRIVACY PRACTICES (CONTINUED)**

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The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- Personnel Manager;
  - Payroll and Benefits Specialists;
  - Financial Manager; and
  - Personnel Committee Members
- The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
  - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

### **Disclosure of Certain Enrollment Information to the Plan Sponsor**

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

### **Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

### **Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

## **HIPAA SECURITY PRACTICES**

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The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

### **Disclosure of Summary Health Information to the Plan Sponsor**

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

### **Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
- Comply with all requirements of the Genetic Information Nondiscrimination Act of 2008 including, but no limited to:
  - Prohibiting the use of genetic information in employment decision making.
  - Restricting deliberate acquisition of genetic information. Maintaining genetic information as a confidential medical record.

## **HIPAA SECURITY PRACTICES (CONTINUED)**

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- Placing strict limits on the disclosure of genetic information.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
  - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

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Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or Health Maintenance Organization offered by the Plan to the Plan Sponsor.

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### **Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.





