

**CITY OF STEVENS POINT  
EMPLOYEE WELFARE BENEFIT PLAN**

**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION**

Effective: JANUARY 1, 2011

Restated: JANUARY 1, 2013

Restated: JANUARY 1, 2016

Third Party Administrator:  
Security Administrative Services  
1515 Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449



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**PLUS MONEY FOR YOU**

Please review your bill carefully for errors such as:

1. Treatment billed but not received;
2. Incorrect arithmetic on the part of the *provider*, or
3. *Drugs* or supplies not received.

**Should you find an error on a bill, request a corrected billing from the *provider* of service. Then submit copies of the original bill with errors circled to the claims department along with the corrected bill as proof the *provider* agreed to the changes. When the adjustments are verified, the City Personnel will authorize a 50% payment of the error, up to a maximum of \$500 per bill, to the *covered person*.**

The following items do not apply to this provision:

- Obvious mathematical errors
- The City, not the *covered person*, initiates the error inquiry

## **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 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*.

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

**Name of Plan:** City of Stevens Point Employee Welfare Benefit Plan

**Plan Sponsor:** City of Stevens Point  
1515 Strongs Ave  
Stevens Point, WI 54481

**Plan Administrator:  
(Named Fiduciary)** City of Stevens Point  
1515 Strongs Ave  
Stevens Point, WI 54481  
715-346-1594

**Plan Sponsor ID No. (EIN):** 39-6005617

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

**Plan Number:** 501

**Plan Type:** Medical  
Prescription Drug

**Third Party Administrator:** Security Administrative Services  
1515 Saint Joseph Ave  
PO Box 8000  
Marshfield, WI 54449

**Participating employer(s):** City of Stevens Point  
1515 Strongs Ave  
Stevens Point, WI 54481

**Agent for Service of Process:** City of Stevens Point  
1515 Strongs Ave  
Stevens Point, WI 54481

**GENERAL PLAN INFORMATION (Continued)**

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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. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

This *Plan* believes it is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act).

## **ELIGIBILITY FOR PARTICIPATION**

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

An eligible employee is a person classified by the employer on both payroll and personnel records as an employee including both part-time and full-time unless specified differently in an applicable bargaining agreement.

You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your eligibility period will begin on the date when you begin work.

An eligible employee who is covered under this *Plan* and who retires under the employer's formal retirement plan will be eligible to continue participating in the *Plan* upon retirement, provided the individual continues to make the required contributions.

An employee may retain eligibility for coverage if temporarily on an approved *leave of absence*, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, and provided contributions continue to be paid on a timely basis.

### **Are my dependents eligible to participate in the Plan?** (See "Definition" section for definition of a *dependent*)

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.**

No *dependent child* may be covered as a *dependent* of more than one employee who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an employee and as a *dependent*.

### **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 first day of the month following 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 30 days following the date of eligibility.
- For a *dependent child* who is born after the date your coverage becomes effective: You must make written application and agree to any required contributions during the first 30 days from the *child's* birth. Coverage for the *dependent child* will then become effective from the moment of birth.
- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required contributions, within 30 days of the date of eligibility.

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

If you did not enroll during your original 30-day eligibility period, and have now decided to apply for coverage, you may do so during the next annual open enrollment or at a special enrollment period. Likewise, if you declined to enroll any of your eligible *dependents* during the original enrollment period, you may apply for coverage for them at a later date in the same manner.

**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 or domestic partner) 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 30 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.

You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or
- 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 30 calendar days after the date the other coverage ended, no later than 30 calendar days after a claim is denied for that reason. 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 or within 60 days of or becoming eligible for premium assistance for Medicaid or a state child health insurance program. 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, completed affidavit of domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your newly acquired *dependent(s)* during a special enrollment period. You must make written application for special enrollment no later than 30 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, qualification for domestic partnership status, 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.:

- For a marriage, on the date of the marriage.
- For a domestic partnership, date of approval of affidavit of domestic partnership.
- For a birth, on the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

**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

## **ELIGIBILITY FOR PARTICIPATION (Continued)**

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*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;
- 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

## **ELIGIBILITY FOR PARTICIPATION (Continued)**

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- 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.

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.

## **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*.

Services which are covered by this *Plan* and which are **not available** through a *PPO network provider* are paid at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*, even when the services are provided by an *non-PPO provider*.

Services provided through a referral by a *PPO network provider hospital*, which are rendered and billed by a *non-PPO provider*, are reimbursed at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*.

Some *PPO network provider hospitals* have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* will reimburse the *hospital* based upon the agreed per diem or DRG rates.

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*.

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*.

## **EMPLOYEE ASSISTANCE PROGRAM**

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Retired and *COBRA covered persons* are not eligible for the following benefit.

**The following is applicable to the actively at work employees.** Your employer recognizes the need to provide a resource for those personal and family stresses that affect everyone at one time or another. The Employee Assistance Program (“EAP”) is a confidential way for individuals, couples and families to obtain professional help to reduce the impact of everyday stresses. EAP services include assessment, counseling, and referral for such problems as *mental or nervous disorders*, family and marital problems, emotional stress, depression and anxiety, *substance abuse*, parent/*child* conflict, and family budgeting.

The City of Stevens Point’s Employee Assistance Program (EAP) is available to *employees* and members of their household (phone: ERC Assist 1-800-222-8590), subject to a maximum of eight (8) counseling sessions per issue..

This program is maintained separately and independently from this *Plan*. Personal information will be kept strictly confidential by the Program Administrator.

Contact your employer for more detailed information about this Program.

## YOUR COSTS

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 providers*. If you use a combination of *PPO network providers* and *non-PPO providers*, your total *deductible* amount required will not exceed the amount shown for *non-PPO providers*. In other words, the amount of *deductible* expense you pay for both *PPO network providers* and *non-PPO providers* will be combined, and the total will not exceed the amount shown for *non-PPO 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 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 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:

- Penalties, legal fees and interest charged by a *provider*.
- Expenses for excluded services.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this *Plan* pays.

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**

**SCHEDULE OF BENEFITS**  
**Transit Union**

This schedule is provided as a convenience only and is not all-inclusive. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read this 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>	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family
<b>Coinsurance</b>	0%	20%
<b>Out of Pocket Maximum*</b> (Deductible and coinsurance)  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.	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family
* The family deductible and out of pocket can be satisfied by <b>one</b> family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Ambulance services</b>	Subject to deductible	Subject to in-network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Autism services</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	Subject to deductible	Subject to deductible and coinsurance
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible	Subject to deductible and coinsurance
<b>Hearing aids and implantable hearing devices</b> (Limited to children up to age 18)	Subject to deductible	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Hearing examinations</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Home health care</b> (Limited to 100 visits per 12 month period)	Subject to deductible	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Home hospice</b> (Limited to 80 visits per 6 month period)</li> </ul>	Subject to deductible	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)</li> </ul>	Subject to deductible	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	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	Subject to in-network deductible and coinsurance
<b>Hospital inpatient services</b> (Including semi-private or special care room, operating room, ancillary services and supplies. Pre-certification required.)	Subject to deductible	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Physician services</b></li> </ul>	Subject to deductible	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Outpatient care</b></li> </ul>	Subject to deductible	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Transitional care</b></li> </ul>	Subject to deductible	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Office visit</b> (Includes chiropractic office visit)	Subject to deductible	Subject to deductible and coinsurance
<b>Outpatient laboratory Services</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Outpatient therapy services</b> (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
• <b>Occupational therapy</b>	Subject to deductible	Subject to deductible and coinsurance
• <b>Physical therapy</b>	Subject to deductible	Subject to deductible and coinsurance
• <b>Speech therapy</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Physician services</b>		
• <b>Hospital services</b>	Subject to deductible	Subject to deductible and coinsurance
• <b>Other services in an office</b>	Subject to deductible (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
<b>Preventive benefit</b> Services must be coded as preventive to be paid under the preventive benefit.		
• <b>Comprehensive physical examination</b> (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• <b>Gynecological examination for women</b> (breast exam and pelvic exam)	Covered at 100%	Subject to deductible and coinsurance
• <b>Digital prostate examination for men</b>	Covered at 100%	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>Comprehensive preventive vision examination</b> (Limited to one exam per calendar year)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Pap smear to screen for cervical cancer</b></li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> </ul>	Covered at 100%	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>	Covered at 100%	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>	Covered at 100%	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>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Chlamydia screening for women</b></li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Ultrasound to screen for an abdominal aortic aneurysm</b></li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Immunizations and vaccinations</b> (including those needed for travel)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Flu vaccine</b> (including FluMist)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	Subject to deductible	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Temporomandibular joint disorders or TMJ nonsurgical treatment</b>	Subject to deductible	Subject to deductible and coinsurance
<b>Transplant services</b>		
• <b>Organ Procurement and acquisition</b>	Subject to deductible	Subject to deductible then covered at 100%
• <b>Transplant procedure</b>	Subject to deductible	Subject to deductible then covered at 100%
• <b>Transportation and lodging</b>	Subject to deductible	Subject to deductible then covered at 100%
• <b>Private duty nursing</b> (Limited to \$10,000 per transplant)	Subject to deductible	Subject to deductible then covered at 100%
• <b>Ambulance service</b> (Limited to \$2,000 per transplant)	Subject to deductible	Subject to deductible then covered at 100%
<b>Vision examinations</b>	Subject to deductible	Subject to deductible and coinsurance
<b>All other covered</b>	Subject to deductible	Subject to deductible and coinsurance

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

**Precertification Required**

Contact Hines and Associates at 800.483.5984 or [www.precertcare.com](http://www.precertcare.com)

- All Inpatient hospitalizations
- Skilled Nursing Facility and Residential Stays
- Transplants
- Physical, Occupational, and Speech therapy after 15 visits per calendar year
- Second Surgical Opinions
- Outpatient surgery including:
  - Abdominoplasty
  - Carpel Tunnel Release
  - Cosmetic/Reconstructive Surgery
  - Hip Replacement
  - Infuse Bone Graft
  - Knee Replacement

**SCHEDULE OF BENEFITS (Continued)**

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- Panniculectomy
- Port Wine Stain – Abnormal Vascular Lesion Treatment
- Reduction Mammoplasty
- Rhinoplasty
- Septoplasty
- Spinal Cord Stimulator

**Pharmacy**

Generic, Brand Name – No Generic Equivalent, and Brand Name

Subject to deductible.

Limited to a 100 day supply.

100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List at [www.securityhealth.org](http://www.securityhealth.org) for a list of covered products.

If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement. Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.

**SCHEDULE OF BENEFITS  
HDHP  
(All active employees EXCEPT Transit Union)**

This schedule is provided as a convenience only and is not all-inclusive. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read this 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>	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family
<b>Coinsurance*</b>	10%	30%
<b>Annual Coinsurance Limit</b>	\$1,000 individual \$2,000 family	\$2,500 individual \$5,000 family
<b>Annual Deductible and Coinsurance Limit</b>	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
<b>Out of Pocket Maximum</b> (Deductible, coinsurance, and medical copayments)  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.	\$6,400 individual \$12,900 family  The individual in-network out of pocket is limited to \$6,400 when enrolled in a family plan.	\$8,900 individual \$17,900 family
* The family deductible and coinsurance can be satisfied by <b>one</b> family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

<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>Autism services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	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 aids and implantable hearing devices</b> (Limited to children up to age 18)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> (Limited to 100 visits per 12 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Home hospice</b> (Limited to 80 visits per 6 month period)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)</li> </ul>	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 until satisfied, then subject to 10% coinsurance after \$100 copayment	Subject to deductible until satisfied, then subject to 10% coinsurance after \$100 copayment
<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> (Including semi-private or special care room, operating room, ancillary services and supplies. Pre-certification required.)	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

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<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 care</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
<b>Office visit</b> (Includes chiropractic office visit)	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
<b>Outpatient therapy services</b> (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
<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></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

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Preventive benefit</b>		
<ul style="list-style-type: none"> <li>• <b>Comprehensive physical examination</b> (complete physical)               <ul style="list-style-type: none"> <li>~ Well-baby care</li> <li>~ Well-child care</li> <li>~ Adolescent well-care</li> <li>~ Adult well-care</li> </ul> </li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<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	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Comprehensive preventive vision examination</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	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	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	Subject to deductible and coinsurance

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
• <b>Chlamydia screening for women</b>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Ultrasound to screen for an abdominal aortic aneurysm</b>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Immunizations and vaccinations</b> (including those needed for travel)	Covered at 100%	Subject to deductible and coinsurance
• <b>Flu vaccine</b> (including FluMist)	Covered at 100%	Subject to deductible and coinsurance
• <b>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)	Covered at 100%	Subject to deductible and coinsurance
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	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>		
• <b>Organ Procurement and acquisition</b>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• <b>Transplant procedure</b>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• <b>Transportation and lodging</b>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• <b>Private duty nursing</b> (Limited to \$10,000 per transplant)	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• <b>Ambulance service</b> (Limited to \$2,000 per transplant)	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<b>Vision examinations</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

**\*\* Case Management Requirement**

Participation in case management is mandatory. When a bill for hospitalization or ER occurs subsequent to a contact/offer from a SAS Case Manager that is declined, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.

**SCHEDULE OF BENEFITS (Continued)**

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

**Precertification Required**

**Contact Hines and Associates at 800.483.5984 or [www.precertcare.com](http://www.precertcare.com)**

- All Inpatient hospitalizations
- Skilled Nursing Facility and Residential Stays
- Transplants
- Physical, Occupational, and Speech therapy after 15 visits per calendar year
- Second Surgical Opinions
- Outpatient surgery including:
  - Abdominoplasty
  - Carpel Tunnel Release
  - Cosmetic/Reconstructive Surgery
  - Hip Replacement
  - Infuse Bone Graft
  - Knee Replacement
  - Panniculectomy
  - Port Wine Stain – Abnormal Vascular Lesion Treatment
  - Reduction Mammoplasty
  - Rhinoplasty
  - Septoplasty
  - Spinal Cord Stimulator

**Pharmacy**

Generic, Brand Name – No Generic Equivalent, and Brand Name

Subject to deductible and coinsurance.

Limited to a 100 day supply.

100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List at [www.securityhealth.org](http://www.securityhealth.org) for a list of covered products.

If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement. Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.

**SCHEDULE OF BENEFITS  
Option 2 Retiree**

This schedule is provided as a convenience only and is not all-inclusive. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read this 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>	\$1,000 individual \$2,000 family	\$2,000 individual \$4,000 family
<b>Coinsurance</b>	20%	40%
<b>Out of Pocket Maximum</b> (Deductible, coinsurance, and copays including prescription 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.	\$2,000 individual \$4,000 family	\$4,000 individual \$8,000 family

<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>Autism services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	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

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Hearing examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> (Limited to 100 visits per 12 month period)	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>Home hospice</b> (Limited to 80 visits per 6 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services</b>		
• <b>Emergency room facility</b> (Copayment waived if admitted within 24 hours)	Subject to deductible and \$50 copayment per visit, then covered at 100%	Subject to in-network deductible and \$50 copayment per visit, then covered at 100%
• <b>Other emergency room services</b>	Subject to deductible then covered at 100%	Subject to in-network deductible then covered at 100%
<b>Hospital inpatient services</b> (Including semi-private or special care room, operating room, ancillary services and supplies. Pre-certification required.)	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>		
• <b>Hospital services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Physician services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Mental health and substance abuse services</b>		
• <b>Inpatient care</b> (Pre-certification required)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Outpatient care</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>
<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> (Includes chiropractic office visit)	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
<b>Outpatient therapy services</b> (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
<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></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>		
<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%	Subject to deductible and coinsurance
<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	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>Digital prostate examination for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Comprehensive preventive vision examination</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	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	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	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Ultrasound to screen for an abdominal aortic aneurysm</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Immunizations and vaccinations</b> (including those needed for travel)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Flu vaccine</b> (including FluMist)</li> </ul>	Covered at 100%	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>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	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>		
<ul style="list-style-type: none"> <li><b>Organ Procurement and acquisition</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transplant procedure</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transportation and lodging</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Private duty nursing</b> (Limited to \$10,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Ambulance service</b> (Limited to \$2,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<b>Vision examinations</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

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

**SCHEDULE OF BENEFITS (Continued)**

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<b>Precertification Required</b> Contact Hines and Associates at 800.483.5984 or <a href="http://www.precertcare.com">www.precertcare.com</a>	
<ul style="list-style-type: none"><li>• All Inpatient hospitalizations</li><li>• Skilled Nursing Facility and Residential Stays</li><li>• Transplants</li><li>• Physical, Occupational, and Speech therapy after 15 visits per calendar year</li><li>• Second Surgical Opinions</li><li>• Outpatient surgery including:<ul style="list-style-type: none"><li>○ Abdominoplasty</li><li>○ Carpel Tunnel Release</li><li>○ Cosmetic/Reconstructive Surgery</li><li>○ Hip Replacement</li><li>○ Infuse Bone Graft</li><li>○ Knee Replacement</li><li>○ Panniculectomy</li><li>○ Port Wine Stain – Abnormal Vascular Lesion Treatment</li><li>○ Reduction Mammoplasty</li><li>○ Rhinoplasty</li><li>○ Septoplasty</li><li>○ Spinal Cord Stimulator</li></ul></li></ul>	

<b>Pharmacy</b>	
Generic	\$10 copayment
Preferred Brand	\$20 copayment
Non-preferred Brand	\$40 copayment
A 100 day supply of prescriptions will require the participant to pay two copayments (applies to retail and mail order).	
If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement. Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.	

**SCHEDULE OF BENEFITS  
Option 3 Retiree**

This schedule is provided as a convenience only and is not all-inclusive. 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>	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
<b>Coinsurance</b>	20%	40%
<b>Out of Pocket Maximum</b> (Deductible, coinsurance and copays including prescription 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.	\$3,500 individual \$7,000 family	\$7,000 individual \$14,000 family

<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>Autism services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	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</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> (Limited to 100 visits per 12 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Home hospice</b> (Limited to 80 visits per 6 month period)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)</li> </ul>	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 within 24 hours)</li> </ul>	Subject to deductible and \$50 copayment per visit, then covered at 100%	Subject to in-network deductible and \$50 copayment per visit, then covered at 100%
<ul style="list-style-type: none"> <li>• <b>Other emergency room services</b></li> </ul>	Subject to deductible then covered at 100%	Subject to in-network deductible then covered at 100%
<b>Hospital inpatient services</b> (Including semi-private or special care room, operating room, ancillary services and supplies. Pre-certification required.)	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 care</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

**SCHEDULE OF BENEFITS (Continued)**

<b>Your Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Office visit</b> (Includes chiropractic office visit)	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
<b>Outpatient therapy services</b> (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
• <b>Occupational therapy</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Physical therapy</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Speech therapy</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Physician services</b>		
• <b>Hospital services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• <b>Other services in an office</b>	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
<b>Preventive benefit</b>		
• <b>Comprehensive physical examination</b> (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• <b>Gynecological examination for women</b> (breast exam and pelvic exam)	1 per calendar year then 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>
<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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Comprehensive preventive vision examination</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	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	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	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	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	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Ultrasound to screen for an abdominal aortic aneurysm</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Immunizations and vaccinations</b> (including those needed for travel)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Flu vaccine</b> (including FluMist)</li> </ul>	Covered at 100%	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>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	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>		
<ul style="list-style-type: none"> <li><b>Organ Procurement and acquisition</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transplant procedure</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transportation and lodging</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Private duty nursing</b> (Limited to \$10,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Ambulance service</b> (Limited to \$2,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<b>Vision examinations</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

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

**SCHEDULE OF BENEFITS (Continued)**

<b>Precertification Required</b>	
<b>Contact Hines and Associates at 800.483.5984 or <a href="http://www.precertcare.com">www.precertcare.com</a></b>	
<ul style="list-style-type: none"> <li>• All Inpatient hospitalizations</li> <li>• Skilled Nursing Facility and Residential Stays</li> <li>• Transplants</li> <li>• Physical, Occupational, and Speech therapy after 15 visits per calendar year</li> <li>• Second Surgical Opinions</li> <li>• Outpatient surgery including:               <ul style="list-style-type: none"> <li>○ Abdominoplasty</li> <li>○ Carpel Tunnel Release</li> <li>○ Cosmetic/Reconstructive Surgery</li> <li>○ Hip Replacement</li> <li>○ Infuse Bone Graft</li> <li>○ Knee Replacement</li> <li>○ Panniculectomy</li> <li>○ Port Wine Stain – Abnormal Vascular Lesion Treatment</li> <li>○ Reduction Mammoplasty</li> <li>○ Rhinoplasty</li> <li>○ Septoplasty</li> <li>○ Spinal Cord Stimulator</li> </ul> </li> </ul>	

<b>Pharmacy</b>	
Generic	\$10 copayment
Preferred Brand	\$20 copayment
Non-preferred Brand	\$40 copayment
<p>A 100 day supply of prescriptions will require the participant to pay two copayments (applies to retail and mail order).</p> <p>If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement. Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.</p>	

## **MEDICAL BENEFITS**

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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.

### **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. Services must be pre-certified.

### **Rehabilitation Facilities Benefits**

*Covered expenses* for *inpatient* rehabilitation facilities include semi-private *room and board* accommodations and necessary ancillary charges. Services must be pre-certified.

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

#### **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.

## **MEDICAL BENEFITS (Continued)**

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### **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.

## **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.

## **Surgical Inpatient and Outpatient Services**

### **Anesthesiologist 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.

## **MEDICAL BENEFITS (Continued)**

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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.

### **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*. Please refer to your *Plan* schedule. You may pay a copay.
- *Emergency* treatment of an *illness*. Please refer to your *Plan* schedule. You may pay a copay.

*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.

### **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* within 7 days 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 as part of a program approved by the *Plan Administrator* for pain management.

#### **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*. Phase I and Phase II only.

#### **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.

## **MEDICAL BENEFITS (Continued)**

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### **Dialysis**

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

### **Therapy Services**

The *Plan* allows coverage for occupational, physical, or speech therapy for Developmental Delays due to an *accident* or *illness* such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy. This *Plan* does not cover services that should legally be provided by a school.

Benefits are provided for therapy services when performed by a licensed physical therapist, chiropractor, or any other *provider* approved by the *Plan*. Therapy must be provided under the direction of the *covered person's physician*.

### **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 occupational 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*.

### **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.

### **Respiratory Therapy**

Benefits are provided for respiratory therapy when performed by a *physician*, licensed respiratory therapist, or any other *provider* approved by the *Plan*. Therapy must be provided under the direction of the *covered person's physician*.

### **Speech Therapy**

Benefits are provided for the evaluation and treatment of *covered persons* who have voice, speech, language, swallowing, cognitive, or hearing disorders. 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*.

### **Massage Therapy**

Benefits are provided for massage therapy services when performed by a licensed physical therapist or chiropractor.

## **MEDICAL BENEFITS (Continued)**

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### **Aquatic Therapy**

Benefits are provided for aquatic therapy services when performed by a licensed physical therapist or any other *provider* approved by 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**

*Covered expenses* include spinal manipulation and other related therapy treatments, and x-rays. Chiropractic care must be rendered for the active treatment of an *illness* or *injury*. Maintenance care is not covered.

#### **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.

- **Gynecology Examination;**
- **Immunizations** including FluMist Vaccinations;
- **Mammogram Test;**
- **Colonoscopy;**
- **Preventive Eye Examinations and Glaucoma Testing;**
- **General Medical Examination by a Physician;**
- **Pap Test;**
- **Preventive Diagnostic Tests, Lab and x-rays;**

## MEDICAL BENEFITS (Continued)

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- **PSA Test and Prostate Exam;**
- **Well Child Care;** and
- **Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).**

### **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*.

### **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 or if *medically necessary* between *hospitals*, between *hospital* and *skilled nursing* facility or from a *skilled nursing* facility or *hospital* to the *covered person's* home.

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*.

Rescue services will be covered when *medically necessary* only to the extent required to allow treatment by on-scene medical personnel.

#### **Autism Services**

The following benefits for treatment of autism spectrum disorder are subject to any applicable *deductible*, coinsurance or copayments. 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 *covered person* 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 *covered person* and be empirically validated for autism spectrum disorders to provide evidence that the *covered person* 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

## **MEDICAL BENEFITS (Continued)**

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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 *covered person* 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 *covered person* or the *covered person'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.

- Intensive-level services

The *Plan* shall provide coverage for evidence-based behavioral intensive-level therapy for a *covered person* with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the *covered person* when the parent or legal guardian is present and engaged 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 *covered person* 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 *covered person's* treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the *covered person's* family and treatment team for implementation of the therapeutic goals developed by the team.
- Commenced after a *covered person* is two years of age and before the *covered person* is nine years of age.
- The *covered person* 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 *covered person* received regardless of payor. The *Plan* may require documentation including medical records and treatment plans to verify any evidenced-based behavioral therapy the *covered person* received for autism spectrum disorders that was provided to the *covered person* prior to the *covered person* attaining nine years of age. The *Plan* may consider any evidence-based behavioral therapy that was provided to the *covered person* 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 *covered person's* treatment plan and the summary of progress on a periodic basis.

- Non-intensive-level services

The *Plan* shall provide coverage for a *covered person* 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 *covered person* 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 *covered person* who has not and will not receive intensive-level services but for whom non-intensive-level services will improve the *covered person's* condition.

## MEDICAL BENEFITS (Continued)

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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 autism spectrum disorders. Treatment plans shall require that the *covered person* 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 *covered person's* treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the *covered person's* family in order to implement the therapeutic goals developed by the team.
- 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 *covered person'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 *covered person* or the *covered person's* authorized representative regarding change in a *covered person's* level of treatment. The notice shall indicate the reason for transition that may include any of the following:
  - The *covered person* has received four cumulative years of intensive-level services.
  - The *covered person* no longer requires intensive-level services as supported by documentation from a qualified *provider* or supervising *provider*.
  - The *covered person* no longer receives evidence-based behavioral therapy for at least 20 hours per week over a six-month period of time.

A *covered person* or a *covered person's* authorized representative must timely notify the *third party administrator* if the *covered person* requires and qualifies for intensive-level services but the *covered person* or the *covered person's* family or care giver is unable to receive intensive-level services for an extended period of time. The *covered person* or the *covered person's* authorized representative shall indicate the specific reason or reasons the *covered person* or the *covered person'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 *covered person* for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a six-month period when the *covered person* or the *covered person's* authorized representative complied with the paragraph above or the *covered person* or the *covered person's* authorized representative can document that the *covered person* 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 *covered person's physician*, that less treatment is medically appropriate.

The following limitations and exclusions apply to this section only:

## MEDICAL BENEFITS (Continued)

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- acupuncture
- animal-based therapy including hippotherapy
- 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 paraprofessionals 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
- 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 *covered person'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 under the prescription *drug* and/or *durable medical equipment* provisions of this *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. It must also demonstrate 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 *covered person's* therapeutic goals and skills as prescribed by a *physician* familiar with the *covered person*.

**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.

## **MEDICAL BENEFITS (Continued)**

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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.

### **Diabetes Treatment**

Pertaining to the Option 2, Option 3

Charges *incurred* for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. Charges are paid the same as any other *Illness*.

Pertaining to the HDHP Plans

Charges *incurred* for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. This also includes use of equipment or supplies. Testing supplies and insulin listed on the preventive medication list are not subject to the deductible.

### **Durable medical equipment (DME)**

*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. Except as otherwise specified in the *Plan* rental or purchase of *durable medical equipment* is subject to the provisions of the Region B DMERC (Durable Medical Equipment Regional Carrier) manual.

### **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, and speech therapy.
- Services provided by a licensed social worker (M.S.W.).
- Services provided by a home health aide, which are *medically necessary* as part of a home care plan, who is under the supervision of a registered nurse or medical social worker, and which consists of solely caring for the patient.

On-going home health services will require re-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.

### **Home Infusion Therapy**

Benefits are available for equipment, services, and supplies provided during the course of home infusion therapy. This does not include services for, or related to, nursing services to administer therapy that you or another caregiver can be successfully trained to administer or services that do not involve direct patient contact, such as delivery charges and recordkeeping

### **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:

## MEDICAL BENEFITS (Continued)

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- *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:**

- **Artificial Limbs, Eyes, and Larynx** when *medically necessary* as a result of an *Illness or Injury*. (Also see prosthetic devices and supplies.)
- **Blood Pressure Cuffs/Monitors** if purchased through a *durable medical equipment* (DME) vendor with a *physician* prescription.
- **Birth control devices, contraceptives and injections** – provided in a *physician's* office. Contraceptives regardless of purpose to include, contraceptives that require a *physician* to administer a hormone shot or insert a device. Prescriptions will be covered under the pharmacy benefit.
- **Blood transfusions and blood products**, to the extent not replaced. The *Plan* will not cover expenses in connection with autologous blood acquisition and storage.
- **Braces, Supports, Trusses, Elastic Compression Stockings and Casts** including any liners or body socks.
- **Cardiac Pulmonary Rehabilitation** when *medically necessary* for activities of daily living, as well as a result of an *illness or injury*.
- **Cleft Palate and Cleft Lip** when treatment is *medically necessary* to include oral *surgery* and pre-graft palatal expander.
- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child*.
- **Cochlear implants** for *covered persons* under the age of 18, who are certified as deaf or hearing impaired by a *physician* or audiologist.
- **Custom-Molded Orthotics**
- **Dental Services** include:

## **MEDICAL BENEFITS (Continued)**

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- The care and treatment of sound natural teeth and gums from a dental *injury*, including but not limited to extraction and initial replacement. The dental *injury* and replacement must occur while covered under the *Plan* and services must begin within 6 months after the date of dental *injury*. Benefits will be paid only for expense *incurred* for the least expensive service that will produce a professionally adequate result.
- Removal of all teeth at an *inpatient* or *outpatient Hospital* or *dentist's* office if removal of the teeth is part of standard medical treatment that is required before the *Covered person* can undergo radiation therapy for a covered medical condition.
- *Hospital* or ambulatory surgical facility for *Covered person*:
  - Professional services for X-ray, lab and anesthesia while in the *hospital* if *medically necessary*
  - *Covered person* has a chronic disability that is attributable to a mental and or physical impairment.
  - *Covered person* has a medical condition that requires hospitalization or general anesthesia for dental care.
- **Feeding Tubes, pumps and bags.**
- **Foot Care including** removal of corns, calluses, toenail or subcutaneous tissue, when prescribed by a *physician* treating metabolic or peripheral vascular disease.
- **Growth hormone therapy** as part of a treatment program approved by the *Plan Administrator*.
- **Hearing Aids** when prescribed by a *physician* or audiologist for *covered persons* under the age of 18 who are certified as deaf or hearing impaired. Coverage is limited to one hearing aid per ear, per *child* every three years. (Benefit applies to HDHP Plans)
- **Hearing Deficit Services** to diagnose and treat a medical condition including exams, tests, services and supplies for other than *preventive care*.. (Benefit applies to Transit Plan and HDHP Plan)
- **Lead Poisoning Screening. Limited to children 6 years of age or younger.**
- **Mammograms.** Including 3-D.
- **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be *medically necessary* and appropriate for an individual's *morbid obesity* condition. This does not include dietary supplements, exercise equipment or any other item listed in the exclusions.
  - Gastric or intestinal bypasses.
  - Charges for diagnostic services.
- **Nutritional Counseling** if *medically necessary* with a medical diagnosis and if provided by a registered dietician.
- **One set of lenses** (with or without frames) following *surgery* for cataracts.
- **Oral surgical procedures**, including:

## **MEDICAL BENEFITS (Continued)**

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- Excision of tumors and cysts of the jaw, cheek, lip, tongue, roof and floor of the mouth.
  - *Emergency* repair due to *injury* to sound natural teeth.
  - *Surgery* needed to correct *accidental* injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - Excision of benign bony growths of the jaw and hard palate.
  - External incision and drainage of cellulitis.
  - Functional osteotomies;
  - Apicoectomy (excision of the apex of the tooth root);
  - Root canal therapy, if performed simultaneously with an apicoectomy;
  - Gingivectomy (excision of gum tissue to eliminate infection);
  - Surgical removal of partially or completely impacted, (non-erupted) teeth;
  - Alveolectomy, if performed for reasons other than for dentures;
  - Frenectomy (incision of the membrane connecting the tongue to the floor of the mouth);
  - Incision of sensory sinuses, salivary glands or ducts.
  - The extraction and initial replacement of a permanent tooth that cannot be restored. A written statement from the dentist indicating that the tooth cannot be restored is required. Benefits for the extraction will not be payable until the initial replacement has been completed. The initial replacement must occur within one year of the date the extraction was performed. The extraction and replacement must both occur while the member is covered under the Plan. Initial replacement of a tooth extracted prior to the member's effective date under the Plan will not be covered. Extractions required for orthodontia treatment are not covered. Dental implants are not covered. **This benefit applies to the HDHP plan only.**
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- **Orthognathic, Prognathic and Maxillofacial *Surgery*** when *medically necessary*.
  - **Orthotic appliances, Devices and Custom-Molded Shoe Inserts.**
  - **Oxygen.**
  - **R.N. and L.P.N.** private duty nursing services for *outpatient* care when *medically necessary*.
  - **Prenatal vitamins.**
  - **Prosthetic devices and supplies**, when *medically necessary* as a result of an *Illness* or *Injury*, including initial purchase price, fitting, adjustment, and repairs. Replacements of prosthetic devices are not covered unless a significant change in the *covered person's* physical structure or the current device cannot be made serviceable.(Also see artificial limbs, eyes, and larynx.)

## **MEDICAL BENEFITS (Continued)**

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- **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*.
- **Reconstructive surgery including:**
  - Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and complications of mastectomies, including lymphedemas. Reimbursement will be made according to the "Schedule of Benefits" section by type of service.
  - Surgery to restore bodily function that has been impaired by a congenital illness or anomaly, accident, or from an infection or other disease of the involved body part.
- **Sterilization procedures, elective.**
- **Temporomandibular Joint Disorder (TMJ) including** surgical and non-surgical treatment of temporomandibular joint dysfunction.
- **Vision Care** including protective lenses following a cataract or aphakia *surgery*, vision therapy or supplies and eye exam and glaucoma testing.

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

The *Plan Administrator* requires that any *covered person* who is a candidate for any transplant procedure contact Hines & Associates at 800.483.5984 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 Centers of Excellence, where a *covered person* may receive care at a negotiated rate for solid organ transplants. Using a Center of Excellence *provider* will normally result in lower costs to the *Plan* and the *covered person*. Please contact Hines & Associates at 800.483.5984 for additional information about Centers of Excellence. Tissue transplants (bone marrow, stem cell or cornea) may be obtained at any PPO *provider*.

Transplant procedures are subject to the following criteria:

- Except for transplant of a cornea, the recipient must be in danger of death in the event the transplant is not performed.
- The prognosis of recovery of the recipient's health or sight, as the case may be, if he were to receive the transplant must be favorable.
- Prior authorization is required.

The following will not be eligible for coverage under this benefit:

- Expenses associated with the purchase of any organ/tissues.
- Charges in connection with mechanical organs or a transplant involving a mechanical organ.
- Services or supplies furnished in connection with the transportation of a living donor.

## **MEDICAL BENEFITS (Continued)**

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*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.

### **Donor**

Charges *incurred* by the donor are only payable if the donor has no other health coverage available, i.e. group health plan, a government program, or a research program.

Travel and Lodging expenses *incurred* immediately prior to and after the transplant will be reimbursed up to \$5,000 for the Covered Individual and a significant other..

Security Administrative Services will provide complete details concerning approved *providers* and *covered expenses*. Please contact them as soon as possible when you know that a transplant procedure is being recommended.

## **EXCLUSIONS AND LIMITATIONS**

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### **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 the following services or supplies:

- **Abortion Charges.** That are *incurred* directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise.
- **Acupuncture or acupressure.**
- **Alternative Treatment and Therapies.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama, megavitamin therapy, holistic or homeopathic medicine or other treatment that is not accepted medical practice as determined by the *Plan*.
- **Assistance with activities of daily living.**
- **Cardiac Rehabilitation** beyond Phase II
- **Corrective Shoes** except if a permanent part of a leg brace.
- **Counseling.** Except as specifically the result of a mental or nervous condition. The Plan does not cover counseling for:
  - Marital difficulties.
  - Social maladjustment.
  - Pastoral issues.
  - Financial issues.
  - Behavioral issues.
  - Lack of discipline or other antisocial action.
- **Custodial care.**
- **Dental prescriptions.** For dental prescriptions (e.g., Peridex, fluoride).
- **Dental Services** for care and treatment of gums, teeth or alveolar process or for dentures, appliances or supplies used in such care or treatment, or *drugs* prescribed in connection with dental care.
  - Dental implants including preparation for implants.

This exclusion does not apply to *hospital* charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an *accident*. Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.

- **Developmental delay** for developmental disorders. Developmental delay is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental delays may not always have a history of birth trauma or other

## **EXCLUSIONS AND LIMITATIONS (Continued)**

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illness that could be causing the impairment such as a hearing problem, mental illness or other neurological symptoms or illness.

- **Drugs** including any medicine or device which does not have the United States Food and Drug Administration (FDA) formal market approval through a New Drug Application, Premarket Approval or 510(k).
- **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical records and itemized bills.
- **Educational.** That are related to education or vocational training.

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*.

- **Examinations** for employment, insurance, licensing, or litigation purposes; or recreation activity.
- **Excess Charges** or the portion thereof which are in excess of the usual and customary charge, the negotiated fee or fee schedule.
- **Experimental, investigational or clinical trials.** No coverage is provided for treatments that are *experimental*, investigational or are still undergoing clinical trials to determine standard treatment protocols. In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental* or investigational, and hence, not covered by this *Plan*. Coverage for routine health care costs *incurred* in conjunction with a cancer clinical trial will be covered in accordance with the terms of Wisconsin Statutes 632.855 (3)(bm) and 632.87 (6). The following criteria is used to determine if 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 *covered person*;
  - 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 investigational, please contact us at 1-800-991-8109. The health services department, utilizing guidance from the technology assessment committee and internal policies as necessary, makes the decision as to whether a procedure is *experimental* or investigational. 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.

- **Excluded providers and facilities.** Treatments or services rendered or provided by the following excluded *providers* or facilities:
  - Hypnotists;
  - Naturopaths;
  - Rolfers; and

## EXCLUSIONS AND LIMITATIONS (Continued)

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- Marriage counselors.
  
- **Eye exercises or training and orthoptics.**  
This exclusion does not apply to Aphakic patients, soft lenses or sclera shells intended for use as corneal bandages, or to one pair of lenses (with or without frames) following cataract *surgery*.
  
- **Food supplements.** Related to food supplements or augmentation, in any form.
  
- **Foot care services, routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, 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.
  
- **Genetic Counseling** regardless of purpose.
  
- **Hearing Deficit Services** unless covered elsewhere in the *Plan*, for purchase or fitting of hearing aids or implantable hearing devices.
  
- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment unless due to an *illness*.
  
- **Infertility treatment.** For *infertility treatment*, including, but not limited to, fertility tests, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, or donor eggs.
  
- **Lamaze classes** or other *child* birth classes.
  
- **Learning Disabilities** for special education, remedial reading, school system testing and other rehabilitation treatment. If a medical condition is identified through the course of diagnostic testing for learning disabilities, any coverage of that medical condition would be subject to *Plan* provisions.
  
- **Liposuction** regardless of purpose.
  
- **Maintenance Therapy.** For service if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition or that clinical evidence indicates a plateau has been reached in terms of improvement from such services
  
- **Mammoplasty or Breast Augmentation** unless covered elsewhere in the *Plan*.
  
- **Marital counseling.**
  
- **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*.
  
- **Nocturnal Enuresis Alarm** for bedwetting.
  
- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed *physician*.
  
- **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.
  
- **Nutrition Counseling** unless covered elsewhere in the *Plan*.

## **EXCLUSIONS AND LIMITATIONS (Continued)**

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- **Obesity treatment.** For the purpose of weight loss.  
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*.
- **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** services or supplies for personal hygiene, comfort or convenience items.
- **Preventive care.** For physical examinations, routine and *preventive care*, except as specifically described in the Schedules of Benefits of the *Plan* in which you are enrolled.
- **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the *Plan*, unless covered elsewhere in this document.
- **Reversal Sterilization** to reverse prior voluntary sterilization.
- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.
- **Tobacco cessation.** For tobacco cessation programs, nicotine gum, nicotine transdermal patches or other treatment of tobacco dependency except as provided under the prescription *drug* section of this *Plan*.
- **Take home drugs or supplies.** For *drugs*, medications or supplies provided by a *hospital*, clinic, *emergency* room or other *provider* which are for use at home.
- **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.
- **Third Party Liabilities and No Fault Covered expenses** to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. These amounts include liability insurance, workers compensation, uninsured motorists, underinsured motorists, no-fault and automobile med pay payments.
- **Travel.** Even though prescribed by a *physician*, unless authorized in advance by the *Plan*.
- **Trusses, corsets and other support devices.**
- **Vision Care** including eye exercises, correction of visual acuity or refractive errors, refraction, eye *surgery* to improve or correct eyesight for refractive disorders including Lasik *surgery*, radial keratotomy, refractive keratoplasty or similar *surgery*, aniseikonia, lenses (single, bifocal, trifocal), frames, contacts, safety lenses and frames, sunglasses or subnormal aids, the fitting or dispensing of non-prescription glasses or vision devices whether or not prescribed by a *physician* or optometrist; except as covered under the *Plan*.

## **EXCLUSIONS AND LIMITATIONS (Continued)**

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- **Vitamins, Minerals and Supplements** Except as provided under the prescription *drug* section of this *Plan*.
- **Wigs.** Care and treatment for hair loss including wigs, hair transplants or any *drug* that promises hair growth, whether or not prescribed by a *physician*.
- **Without approval. Treatment, services and supplies** furnished without recommendation and approval of a *physician* acting within the scope of his or her license.
- **Workers' Compensation or Employment** Bodily *Injury* or *illness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law when coverage was available and such coverage was actually purchased.

### **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.
- **Cosmetic.** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising therefrom) except specifically noted under covered benefits.
  - 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 lymphademas, in a manner determined in consultation with the attending *physician* and the *covered person*.
- **Court-ordered Treatment or Therapy** ordered as a condition of parole, probation, or custody or visitation evaluation unless such treatment or therapy is normally covered by this Plan. This *Plan* does not cover the cost of driving while intoxicated classes or other classes ordered by the court.
- **Deductibles, Copayments and Coinsurance.**
- **Forms.** For the completion of medical reports, claim forms or itemized billings.
- **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 by a *covered person*.
- **Immediate relative.** Provided by an *immediate relative* or an individual residing in your home.

## **EXCLUSIONS AND LIMITATIONS (Continued)**

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- **Late Claims.** For which the claim is received by the *Plan* after the maximum period for filing claims under this *Plan* has expired.
- **Malpractice.** That are required as a result of malpractice, malfeasance or that are to treat injuries that are sustained or an *illness* that is contracted, including infections and complications, while the *covered person* was under the care of a *provider* for a condition wherein such *illness, injury, infection* or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator* in its sole discretion, gave rise to the expense.
- **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. 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.**
- **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 benefits.
- **Subrogation.** That are not payable under the *Plan* by virtue of its subrogation provisions. This shall include any covered expenses incurred for an illness or injury for which a third party is considered responsible.
- **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.
- **Telephone consultations.** For telephone consultations.
- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication thereof. 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).

## COST CONTAINMENT PROVISIONS

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Hines & Associates, Inc. has been engaged by Security Administrative Services to provide health cost management services. (Prior to January 1, 2016, Security Health Plan provided these services.) Hines is staffed by *physicians* and registered nurses with clinical experience, and their organization has earned national accreditation. These medical professionals can assist you during treatment, to assure that you have access to *medically necessary* care at the appropriate level for your condition.

Hines outreach services include pre-certification of confinement and high-cost services (this is generally a conversation between your *physician's* office and Hines), case management, (a requirement of your *plan* if you are contacted and want the highest benefit) and disease management. Your cooperation and participation in these services can help control plan costs, your contribution toward coverage, and your *out-of-pocket* expenses.

### **Pre-certification Program**

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 between you, your attending *physician* and the Pre-certification Program administrator (Hines & Associates) to discuss the proposed course of treatment and any options that may be available for your treatment. Medical management determines whether the treatment is considered *medically necessary*, which is one of the required elements for reimbursement under the *plan*. The medical manager 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 medical management at least 1 working day before any of the following services are performed. For *emergency* and urgent admissions, you must contact medical management within 2 working days following the 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.

You are responsible for notifying medical management at 800.483.5984 or [www.precertcare.com](http://www.precertcare.com) before you receive the following services:

- All *Inpatient* hospitalizations
- Occupational Therapy, Physical Therapy, or Speech Therapy after 15 visits per year
- Second Surgical Opinion
- *Skilled Nursing Facility* and Residential Stays
- Transplants
- *Outpatient* Surgery Including:

## **COST CONTAINMENT PROVISIONS (Continued)**

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- Abdominoplasty
- Carpel Tunnel Release
- Cosmetic/Reconstructive Surgery
- Hip Replacement
- Infuse Bone Graft
- Knee Replacement
- Panniculectomy (excess skin removal)
- Port Wine Stain – Abnormal Vascular Lesion Treatment
- Reduction Mammoplasty
- Rhinoplasty
- Septoplasty
- Spinal Cord Stimulator

### **Utilization Management**

Utilization management is designed to assist covered persons in making informed medical care decisions resulting in the delivery of appropriate levels of *Plan* benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's *physician*. The patient and his or her *physician* determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of *Plan* benefits is not determined through these processes. The utilization management program is administered by Hines & Associates.

### **Concurrent Review**

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

Medical management 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.

**A pre-certification, utilization management or concurrent review determination by the *Plan* under this provision will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.**

**Pre-determination of Medical/Surgical Benefits**

This is a service offered by the *Plan* to help you determine, in advance, whether a proposed treatment will be a covered expense under the *Plan*. It is a voluntary provision, and you are under no obligation to obtain pre-approval of your treatment. However, you are encouraged to use this service to avoid incurring non-covered expenses for which you will be responsible.

In order to evaluate the proposed treatment, the *Plan Administrator* will require detailed medical information from your *physician*, including:

- The identity of the patient (including date of birth and sex);
- The diagnosis code (ICD);
- The procedure code (CPT); and
- The amount of the proposed charge.

This information should be submitted to:

**Security Administrative Services**

**PO Box 8000**

**Marshfield WI 54449**

**800.570.8760**

Types of services which are recommended for predetermination include the following:

- Blepharoplasty (eyelid surgery)
- Rhinoplasty (nose surgery)
- Virtual Colonoscopy
- Varicose Vein Treatment
- Other services that may be viewed as *cosmetic, experimental or investigational*, or not *medically necessary*

You will receive a written response with the *Plan Administrator's* determination, which you may furnish to your *physician* if you so desire. **A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.**

## **COST CONTAINMENT PROVISIONS (Continued)**

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Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health in order to pre-determine benefits. Pre-determination of benefits is not recommended under these circumstances.

### **Case Management Program**

In certain circumstances, especially in the case of a very serious *illness* or *injury*, the *Plan* may make available its Case Management Program services to the covered person. This is strictly a voluntary program; no covered person is obligated to participate and benefits will not be adversely affected.

Case managers are medical professionals who will work with your attending *physician* to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your physician throughout the course of treatment. If you have any questions about the Case Management Program, please feel free to contact Hines & Associates at 800.483.5984.

### **Case Management: HDHP Plan Participants**

When contacted by the *Plan's* case management services, failure to participate will result in a reduction of medical benefits. Covered expenses for hospitalization or emergency room services incurred subsequent to declining case management or disease management services will be reduced \$300. This reduction will NOT be considered for payment, and the penalty will not apply to satisfy the *deductible* or *out-of-pocket* requirements of the health care plan. The balance of covered expenses would be considered subject to plan provisions.

If at any point during treatment for an *illness* or *injury* the covered person wishes to participate in case management or disease management services, the covered person must contact Hines & Associates at 800.483.5984:

Any charges that were incurred prior to the date the covered person called to accept case management or disease management services and considered for payment by the administrator will NOT be reconsidered. The penalties assessed are the responsibility of the covered person.

## **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 a participating pharmacy.

**The *Plan's* Prescription Program has a network of pharmacies, which can identify *covered persons* and the *Plan's* coverage provisions. To find out which pharmacies participate, contact Security Administrative Services at 1-800-570-8760.**

### **Covered Prescriptions**

Under the Prescription Drug Card Program, *covered expenses* include:

- Birth control products that require a written prescription or oral contraceptives.
- Federal legend *drugs* with a valid NDC number.
- State-restricted *drugs*.

## **PRESCRIPTION DRUG BENEFIT (Continued)**

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- Insulin. Insulin not on the *Plan* formulary may require medical exception review for coverage to be considered.
- Flu vaccine (including FluMist) administered at a pharmacy.
- Syringes and needles used only to inject insulin.
- Self-administered arthritic needles.
- Prescription prenatal vitamins.
- Tobacco cessation products.
- Non-combination Prescriptions requiring products containing vitamins A, D, E, or K.
- Services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force including aspirin therapy, fluoride treatment etc.

Certain *drugs* are limited or excluded, even when prescribed by your *physician*. Please refer to the *Plan* formulary, list of excluded drugs below, and the "Schedule of Benefits".

### **How the Program Works**

To fill a prescription at a participating pharmacy, 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.

### **Quantity Limits and Step Therapy Drugs**

Certain provisions apply to the coverage of some drugs on the formulary.

- Quantity limits – limits the maximum amount allowed per dispensing or time period.
- Step therapy - first line agents must be tried and failed before this drug may be dispensed to you.
- Prior authorization – prior authorization must be obtained by your provider before coverage of these drugs will be approved.
- Specialty medications must be received through the approved specialty pharmacy.

### **Prescription Product Exclusions**

- Anorexants (weight control *drugs*).
- *Experimental* or investigational *drugs*, including compounded medications for non-FDA-approved use.
- *Drugs* that are not *medically necessary* for the treatment of an *illness* or *injury* as determined by the *Plan Administrator*.
- Fertility products.
- Provided in or through a *physician's* office, clinic or *hospital* to be taken home and used.
- *Drugs* to treat sexual dysfunction unless *medically necessary* and specifically covered under the formulary as *medically necessary*; subject to limited coverage and quantity limits for the HDHP *Plan*.
- *Cosmetic* agents (including Renova, hair removal or hair growth products).
- *Drugs* used to enhance athletic performance.
- Vitamins (except prescription prenatal vitamins).

**PRESCRIPTION DRUG BENEFIT (Continued)**

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- Shampoos, soaps and detergents.
- Workers' Compensation: prescriptions that a *covered person* is entitled to receive, without charge, under any workers' compensation law, or under any municipal, state or federal program.

**In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following under this prescription drug benefit provision:**

Charges which are in excess of the contracted amount.

Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments and other non-medical substances, without regard to their intended use.

Immunization agents (except the Flu shot and FluMist vaccine), biological sera, blood or blood plasma.

Products labeled: "Caution-limited by federal law to Investigational use", or *experimental drugs* even though a charge is made to the *covered person*. Approved prescription products which are prescribed for *experimental* or investigational purposes or in *experimental* or investigational dosages.

Any charge for the administration of prescription products.

Any medication, prescription or non-prescription, which is taken or administered at the place where it is dispensed.

Any medication which is meant to be taken by or administered to the *covered person*, in whole or in part, while the *covered person* is treated at a *hospital*, a *physician's office (or extended care)* facility but is instead self-administered or administered elsewhere, unless expressly designated by the Pharmacy Benefits Administrator.

Refilling a prescription in excess of the number specified on the prescription or any refill dispensed after one year from the order of the medical professional.

Prescription products which are not dispensed by a licensed pharmacist or medical professional.

Prescription products dispensed in a foreign country, if you traveled solely for the purpose of re-importing prescription *drugs* into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States.

Prescriptions that are *cosmetic* in nature, unless the prescription is necessary to ameliorate a deformity arising from, or directly related to a congenital abnormality, a personal *injury* resulting from an *accident* or trauma or disfiguring disease.

Prescription products which may be received without charge under local, state or federal programs, including workers' compensation.

Replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

Rogaine, or any other *cosmetic* hair growth prescription products.

Prescription products, if a prior authorization was needed but not requested; and prescription products, if prior authorization was requested but denied.

**PRESCRIPTION DRUG BENEFIT (Continued)**

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Anabolic steroids.

Prescription products available over-the-counter that do not require a prescription order by federal or state law and any medication that is equivalent to an over-the-counter medication.

Anorectics or any other products used for the purpose of weight control.

Legend topical acne products for a *covered person* who is over age 25, unless determined *medically necessary* by the *Plan*.

Approved prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.

Prescription products used to enhance sexual function or satisfaction, unless determined *medically necessary* by the *Plan*.

Infertility products, unless used to sustain a *covered person's pregnancy*.

Prescription products that are determined by the Pharmaceutical and Therapeutics Committee to be either marginally effective and/or are excessive in cost when compared to alternative medication for the same condition.

Growth hormone products.

All illegal medications or supplies, even if prescribed by a duly licensed medical professional.

## **TERMINATION OF COVERAGE**

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

Your coverage under this *Plan* will end at 12:01 A. M. on the earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this *Plan* is canceled; or
- The date coverage for your benefit class is canceled; or
- The day of the month in which you tell the *Plan* to cancel your coverage if you are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or
- The last day of the month in which you are no longer a member of a covered class, as determined by the employer; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan; or
- The last day of the month in which your employment ends except for qualified retirees.

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

Coverage for your *dependents* will end at 12:01 A. M. on the earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution toward the cost of your *dependent's* coverage when due; or
- The day of the month in which your coverage ends except in the event that the *employee* dies, coverage for the surviving spouse can continue for the rest of the spouse's life, provided that the surviving spouse pays the applicable contribution when due; or
- The spouse of a retiree that retired from service at the retirement age based on their Wisconsin Retirement Fund Category (age 55 for general employees and age 50 for protective services), or retiree due to disability and apply for a retirement annuity from the Wisconsin Retirement Fund and their covered dependents is eligible to continue on the plan following the retiree's death or entitlement to Medicare provided he/she continues to make required contributions for coverage. If a surviving spouse remarries, coverage will be limited to only the surviving spouse of the retiree.
- The last day of the month in which your *dependent* is no longer your legal spouse due to legal separation or divorce, as determined by the law of the state where the *employee* resides; or
- In the case of a *child* for whom coverage is being continued due to mental or physical disability, the last day of the month in which the earliest event occurs:
  - Cessation of the disability
  - Failure to furnish any required proof of the uninterrupted continuance of the disability or to submit any required examination
  - The *child* is no longer *dependent* on you for his support
- The day of the month in which you tell the *Plan* to cancel your *dependent's* coverage if you are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or

## **TERMINATION OF COVERAGE (Continued)**

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- In the case of a *child* (other than a *child* for whom coverage is continued due to mental or physical disability), the last day of the month on which the *child* reaches age 26; or
- The date you or your *dependent* submits a false claim or are involved in any other form of fraudulent act related to this *Plan*.
- For a covered grandchild until the earlier of the date the *employee's* covered *dependent* (who is the parent of the grandchild) reaches age 18 or otherwise no longer an eligible *dependent* under the *Plan*.

### **Will the Plan provide evidence of coverage?**

The *Plan* generally will automatically provide a certificate of coverage to anyone who loses coverage in the *Plan*. In addition, a certificate of coverage will be provided upon request within 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the certificate of coverage, but the *Plan* will not issue an automatic certificate of coverage for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

### **Reinstatement of Coverage**

Coverage will be continued for you and your *dependent* should the following occur:

In the event you take a *leave of absence*, which does not meet the requirements of *FMLA*, your coverage will continue until the last day of the month. The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under *COBRA*.

If your coverage ends due to termination of employment, *leave of absence* or lay-off and you later return to active work, you are eligible for coverage on the first of the month following the date of return to *active employment* for the participating employer.

### **May I continue participation during FMLA leave or WFMLA leave?**

An *employee* eligible for Federal and/or Wisconsin family and medical leave may continue coverage under this *Plan* during a period of approved leave at the same cost as if the leave had not been taken. Federal and Wisconsin leave will run concurrently if an *employee* is eligible for both leaves.

If the provisions under the *Plan* change while you are on *FMLA* or *WFMLA leave*, the changes will be effective for you on the same date as they would have been had you not taken leave.

### **Am I an eligible employee?**

#### *FMLA*

1. If you have been employed with the *participating employer* for at least 12 months; and
2. If you have been employed with the *participating employer* at least 1,250 hours during the 12 consecutive months prior to the request for *FMLA leave*; and
3. If you are employed at a worksite that employs at least 50 *employees* within a 75 mile radius.

#### *WFMLA*

1. If you have been employed with the *participating employer* for at least 52 consecutive weeks; and
2. If you have been employed with the *participating employer* at least 1,000 hours in the preceding 52 weeks; and

## **TERMINATION OF COVERAGE (Continued)**

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3. If you are employed at a worksite that employs at least 50 permanent *employees* during at least six of the preceding 12 calendar months.

### **What circumstances qualify for FMLA or WFMLA leave?**

#### *FMLA*

1. The birth of, and to care for, your son or daughter;
2. The placement of a *child* with you for adoption or foster care;
3. Your taking leave to care for your spouse, domestic partner, son, daughter or parent who has a serious health condition;
4. Your taking leave due to a serious health condition which makes you unable to perform the functions of your position;
5. Your taking leave due to any qualifying exigency arising out of the fact that your spouse, domestic partner, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation (Qualifying Exigency Leave); or
6. Your taking leave for up to a total of 26 workweeks in a single 12 month period to care for a covered service member with a serious *injury* or *illness* (Military Caregiver Leave) when you are the service member's spouse, domestic partner, parent, son, daughter or next of kin.

You may elect (or the *participating employer* may require) accrued paid leave to be used in some cases. You may not elect paid sick leave or paid vacation leave for any situation not covered by the *participating employer's* leave *Plan*.

#### *WFMLA*

1. The birth of, and to care for your son or daughter;
2. The placement of a *child* with you for adoption or foster care;
3. Your taking leave to care for your spouse, son, daughter, parent, parent-in-law, or domestic partner who has a serious health condition; or
4. Your taking leave due to a serious health condition which makes you unable to perform the functions of your position.

This leave may be paid (accrued vacation time or sick leave, as applicable) or unpaid within the limits set by Wisconsin law.

If you qualify for both *FMLA* and *WFMLA leave*, your leave counts against the entitlement for both leaves concurrently. You must continue to pay your portion of the *Plan* contribution, if any, during the *FMLA* or *WFMLA leave*.

Payment must be made within 30 days of the due date established by the *Plan Administrator*. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

### **What are the notice requirements for FMLA and WFMLA leave?**

You must provide at least 30 days' notice (for *FMLA*) or in advance in a reasonable and practicable manner (for *WFMLA*). If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your *participating employer* has the right to require medical certification to support your request for leave due to a serious health condition for yourself or your eligible family members or the circumstances supporting the need for qualifying exigency leave or military caregiver leave.

## **TERMINATION OF COVERAGE (Continued)**

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### **How long may I take for FMLA and WFMLA leave?**

#### *FMLA*

1. During a calendar year, the maximum amount of *FMLA leave* may not exceed 12 workweeks except as allowed for Military Caregiver Leave or Qualifying Exigency Leave.
2. If you and your spouse are both employed by the *participating employer*, *FMLA leave* may be limited to a combined period of 12 workweeks, both spouses, when *FMLA leave* is due to:
  - a. The birth or placement for adoption or foster care of a *child*; or
  - b. The need to care for a parent who has a serious health condition.

#### *WFMLA*

1. During a calendar year, you may take six workweeks for birth or adoption; two workweeks for the serious health condition of a parent, *child*, spouse, parent-in-law, domestic partner, or parent of a domestic partner.

### **Will FMLA and/or WFMLA leave terminate before the maximum leave period?**

Coverage may end before the maximum 12-week, 6 week, or 2 week period under the following circumstances:

1. When you inform your *participating employer* of your intent not to return from leave.
2. When your employment relationship would have terminated but for the leave (such as during a reduction in workforce).
3. When you fail to return from the leave; or
4. If any required *Plan* contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under *FMLA/WFMLA leave* ends, you will be eligible for *COBRA* continuation of coverage at that time.

### **Recovery of Plan contributions**

Your *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/WFMLA leave* if you do 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 you to *FMLA/WFMLA leave* (in which case your *participating employer* may require medical certification) or other circumstances beyond your control.

### **Will my coverage be reinstated when I return to work?**

The law requires that coverage be reinstated upon your return to work following an *FMLA/WFMLA leave* whether or not you maintained coverage under the *Plan* during the *FMLA/WFMLA leave*.

On reinstatement, all provisions and limits of the *Plan* will apply as they would have applied if *FMLA/WFMLA leave* had not been taken.

### **Definitions**

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

**“WFMLA”** is Wisconsin Family and Medical Leave Act.

**“Serious health condition”** is an *illness, injury*, impairment or physical or mental condition that involves:

1. *Inpatient* care in a *hospital*, hospice or residential medical facility; or

## **TERMINATION OF COVERAGE (Continued)**

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2. Continuing treatment by a health care *provider*, a doctor of medicine, or osteopathy who is authorized to practice medicine or *surgery*, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services.

**“Spouse”** is your husband or wife.

**“Son or Daughter”** is your biological *child*, adopted *child*, *stepchild*, foster *child*, a *child* placed in your legal custody or a *child* for whom you are acting as the parent in place of the *child’s* natural blood related parent. The *child* must be:

1. Under the age of 18 (*FMLA* only); or
2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

**“Parent”** is your biological parent or someone who has acted as your parent in place of your biological parent when you were a son or daughter.

**“Son or daughter on active duty”** or **“call to active duty” status** is a son or daughter on active duty or “call to active duty” status, the *employee’s* biological, adopted, or foster *child*, *stepchild*, legal ward, or a *child* for whom the *employee* stood in loco parentis, who is on active duty or call to active duty status, and who is of any age.

**“Son or daughter of a covered service member”** is the service member’s biological, adopted, or foster *child*, *stepchild*, legal ward, or a *child* for whom the service member stood in loco parentis, and who is of any age.

**“Parent of a Covered Service Member”** is a covered service member’s biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the covered service member. This term does not include parents “in law”.

**“Next of Kin of a Covered Service Member”** is (in the following order of priority): Blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the *FMLA*. When no such designation is made, and there are multiple family members with the same level of relationship to the covered service member, all such family members shall be considered the covered service member’s next of kin and may take *FMLA leave* to provide care to the covered service member, either consecutively or simultaneously. When such designation has been made, the designated individual shall be deemed to be the covered service member’s only next of kin.

**“Qualifying Exigencies”** are one of the following when due to or related to the active duty or call to active duty status of a covered military member. For purposes of this provision a *child* is a biological, adopted, or foster *child*, a *stepchild*, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence:

- (1) Short-notice deployment. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
- (2) Military events and related activities. To attend any official ceremony, program, or event sponsored by the military and to attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross;
- (3) Childcare and school activities. To arrange for alternative childcare, or to provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis), or to enroll a *child* in or transfer a *child* to a new school or day care facility; and to attend meetings with staff at a school or a daycare facility, such as meetings

## **TERMINATION OF COVERAGE (Continued)**

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with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors.

(4) Financial and legal arrangements. To make or update financial or legal arrangements to address the covered military member's absence, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;

(5) Counseling. To attend counseling provided by someone other than a health care *provider* for oneself, for the covered military member, or *child*, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

(6) Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. The eligible *employees* may take up to five days of leave for each instance of rest and recuperation;

(7) Post-deployment activities. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and to address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements;

(8) Additional activities. To address other events that arise out of the covered military member's active duty or call to active duty status provided that the employer and *employee* agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

Active duty or call to active duty status means duty under a call or order to active duty (or notification of an impending call or order to active duty) in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code, which authorizes ordering to active duty retired members of the Regular Armed Forces and members of the retired Reserve who retired after completing at least 20 years of active service; Section 12301(a) of Title 10 of the United States Code, which authorizes ordering all reserve component members to active duty in the case of war or national *emergency*; Section 12302 of Title 10 of the United States Code, which authorizes ordering any unit or unassigned member of the Ready Reserve to active duty; Section 12304 of Title 10 of the United States Code, which authorizes ordering any unit or unassigned member of the Selected Reserve and certain members of the Individual Ready Reserve to active duty; Section 12305 of Title 10 of the United States Code, which authorizes the suspension of promotion, retirement or separation rules for certain Reserve components; Section 12406 of Title 10 of the United States Code, which authorizes calling the National Guard into federal service in certain circumstances; chapter 15 of Title 10 of the United States Code, which authorizes calling the National Guard and state military into federal service in the case of insurrections and national emergencies; or any other provision of law during a war or during a national *emergency* declared by the President or Congress so long as it is in support of a contingency operation.

This provision does not apply to an *employee* whose family member is on active duty or "call to active duty" status in support of a contingency operation as a member of the Regular Armed Forces nor due to state calls to active duty unless under order of the President of the United States pursuant to one of the provisions of law identified above.

**NOTE: For complete information regarding your rights under FMLA, contact your participating employer**

### **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:

## **TERMINATION OF COVERAGE (Continued)**

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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 that 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 100% 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 within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to in (i).
  - b. For leaves of 30 to 180 days, by submitting an application for reemployment with your *participating employer*, (i) not later than 14 days after completing uniformed service, or (ii) if submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.
  - 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.

## **TERMINATION OF COVERAGE (Continued)**

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- 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* (depending upon the length of your leave as indicated above), 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 making 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
2. 18 months from the date your leave began.

Continued coverage provided under this provision will 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*.

### **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 that 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 considered for continuation under *COBRA*.

Continuation will be available up to the maximum time period shown below. Multiple qualifying events that 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.

## **TERMINATION OF COVERAGE (Continued)**

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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*.

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*;
- 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.

Two provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 72.5% tax credit for premiums paid for

## **TERMINATION OF COVERAGE (Continued)**

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certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA* continuation within the election period will be allowed an additional 60-day period to elect *COBRA* continuation coverage. If the qualified beneficiary elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

### **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.

### **Reinstatement of Coverage**

If your coverage ends due to termination of employment, *leave of absence* or lay-off and you later return to active work, you are eligible for coverage on the first of the month following the date of return to active work for this company. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact your personnel office.

### **Trade Act Provisions affecting COBRA**

Two provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 72.5% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA* continuation within the election period will be allowed an additional 60-day period to elect *COBRA* continuation coverage. If the qualified beneficiary elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

### **Additional Information**

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

City of Stevens Point  
1515 Strongs Ave  
Stevens Point WI 54481

### **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 Associate; 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*

## **CLAIM PROCEDURES (Continued)**

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*administrator*; provided, however, that 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 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

## CLAIM PROCEDURES (Continued)

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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.

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.

## **CLAIM PROCEDURES (Continued)**

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### **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 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.

### **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

## **CLAIM PROCEDURES (Continued)**

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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 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;

## CLAIM PROCEDURES (Continued)

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- 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).
- 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;

## **CLAIM PROCEDURES (Continued)**

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- 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.

## **Second Level Appeal**

### **Requirements for Second Appeal**

Upon receipt of notice of the *Plan*'s adverse decision regarding the first appeal, the *covered person* has 60 days to file a second appeal of the *adverse benefit determination*. The *covered person* again is entitled to a “full and fair review” of any *adverse benefit determination* made at the first appeal, which means the *covered person* has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the *covered person*'s second appeal must be in writing and must include all of the items set forth in the section entitled “Requirements for First Appeal.”

### **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.
- 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.

### **Manner and Content of Notification of Adverse benefit determination on Second Appeal**

The same information must be included in the *Plan*'s response to a second appeal as a first appeal.

### **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.**

#### **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:

## **CLAIM PROCEDURES (Continued)**

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- Benefits may not be assigned to a non-U.S. *provider*;
- 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 *illness*) 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 *illness*) 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 trustees 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, homeowners or other similar insurance, this *Plan* will always be considered the secondary carrier regardless of the individual’s election under personal *injury* protection (PIP) coverage with the insurance carrier.

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

## **COORDINATION OF BENEFITS (Continued)**

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- 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 claim 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.

### **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.

## **COORDINATION OF BENEFITS (Continued)**

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### **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 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*. 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*.

### **Protection Against Creditors**

No benefit payment under this *Plan* will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Company will find that such an attempt has been made with respect to any payment due or to become due to any *covered person*, the Company in its sole discretion may terminate the interest of such *covered person* or former *covered person* in such payment, and in such case will apply the amount of such payment to or for the benefit of such *covered person* or former *covered person*, his spouse, parent, domestic partner, adult *child*, guardian of a minor *child*, brother or sister, or other relative of a *dependent* of such *covered person* or former *covered person*, as the Company may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment.

## **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 *illness* 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. 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**

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

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”**

“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 *illness* 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.

**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 *illness*) 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 *illness*) 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 the italicized words used 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.

“**ADA**” means the American Dental Association.

“**AHA**” means the American *Hospital* Association.

“**AMA**” means the American Medical Association.

“**Adverse Benefit Determination**” means any of the following:

- a denial, reduction or termination of, or 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 your eligibility to participate in a plan, including resulting from the application of any utilization review,
- the failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental* or investigational or not *medically necessary* or appropriate

“**Ambulance Transportation**” means professional ground or air ambulance transportation in an *emergency* situation or when deemed *medically necessary*, which is

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of you or your *dependent*.

“**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 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.

## **DEFINITIONS (Continued)**

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**“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)”** A *dependent child* until the *child* reaches his or her 26<sup>th</sup> birthday. The term *child* includes the following *dependents* who meet eligibility criteria listed below:

The *employee’s* own blood descendant of the first degree or lawfully adopted *child*, any *stepchild* residing with the *employee*, 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, 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. A grandchild as long as the *employee’s* covered *dependent* is the parent of the grandchild. Coverage for the grandchild will end when the *employee’s* covered *dependent* (parent of *child*) turns age 18.

**“Chiropractic care”** means office visits, x-rays, manipulations, supplies, heat treatment, cold treatment.

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

**“Company”** means City of Stevens Point

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

## **DEFINITIONS (Continued)**

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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.

Creditable shall not include coverage for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of *creditable coverage* shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under the plan.

**"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*.

**"Dentist"** means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice *dentistry* in the jurisdiction where such services are provided.

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

- An *employee's* lawfully wed spouse possessing a marriage license who is not divorced from the *employee*;
- An *employee's*, spouse's or domestic partner's child who:
  - Is under the age of 26;
  - Is a full-time student, if the *child* was called to federal active duty in the National Guard or in a reserve component of the US armed forces while the *child* was under 26 years of age when attending, on a full-time basis, an institution of higher learning. To qualify, the *child* must apply to an institution of higher education as a full-time student within 12 months from the date the *child* fulfilled his or her active duty obligation.
  - Was continuously covered prior to attaining the limiting age above, who is mentally or physically disabled, unable to sustain his own living, and is still primarily *dependent* upon the *employee* for support. Such *child* must have been mentally or physically disabled prior to attaining the limited age under the second and third bullets. 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.
- If a *child* is born to an *employee's* covered *dependent*, that grandchild of the *employee* is an eligible *dependent* until the earlier of the date the *employee's* covered *dependent* (who is the parent of the grandchild) reaches age eighteen or otherwise no longer an eligible *dependent* under the plan.
- An *employee's* registered and declared domestic partner and the children of such partner (applies ONLY to active employees enrolled on the Transit Plan and HDHP City of Stevens Point Employee Medical Plan).

*"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.

## **DEFINITIONS (Continued)**

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

**“Detoxification”** means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of *substance abuse*, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, *drug* impairment, alcohol dependency factors or alcohol in combination with *drugs* as determined by a licensed *physician*, while keeping the physiological risk to the patient to a minimum.

**“Developmental delay(s)”** is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental delays may not always have a history of birth trauma or other illness that could be causing the impairment such as a hearing problem, mental illness, or other neurological symptoms or illness.

**“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*.

**“Domestic Partner”** is a registered or unregistered person of the same or opposite sex who resides with you, is at least 18 years old, unmarried nor in a domestic partnership with another person, and not closer to each other than second cousins, whether of the whole or half blood or by adoption.

**“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.

**“Effective date”** means, January 1, 2011, the first day of coverage under this *Plan* as defined in this document.

**“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, 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 classified by the employer on both payroll and personnel records as an *employee* including both part-time and full-time unless specified in applicable bargaining agreements. An *employee* is not a seasonal, temporary or leased *employee* or an *independent contractor*.

**“Enrollment date”** means:

## **DEFINITIONS (Continued)**

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- For anyone who applies for coverage when first eligible, the *enrollment date* is the date that coverage begins, or if there is a *waiting period*, the first day of the *waiting period*, whichever is earlier.
- For anyone who enrolls under the special enrollment provision, the *enrollment date* is the first day of coverage
- For *late enrollees*, the *enrollment date* is the first day of coverage.

**“Experimental”** 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 Administration and the AMA’s Council on Medical Specialty Societies.

*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 of the condition for which they are prescribed.

**“Family unit”** means the *employee*, his or her spouse, domestic partner, and the *dependent children* of the employee, spouse, or domestic partner. Domestic partner coverage is applicable only for active employees enrolled on the Transit Plan or HDHP City of Stevens Point Employee Medical Plan.

**“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*.

**“Generic drug”** means *drugs* not protected by a trademark, usually descriptive of drug’s chemical structure.

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

**“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:

## **DEFINITIONS (Continued)**

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- 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.

**“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;
- 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
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

## **DEFINITIONS (Continued)**

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The requirement of surgical facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such institution is accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

**“Illness”** means a condition, 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, 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.

**“Independent contractor”** means an entity or individual who performs services to or on behalf of the employer who is not an *employee* or an officer of the employer and who retains control how the work gets done. The employer who hires the *independent contractor* controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an *independent contractor* shall be made consistent with section 530 of the Internal Revenue Code.

**“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.

**“Infertility treatment”** means services, tests, supplies, devices, or *drugs* which are intended to promote fertility, achieve a condition of *pregnancy*, or treat an *illness* causing an infertility condition when such treatment is done in an attempt to bring about a *pregnancy*.

See definition of Fertility Treatment above.

**“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*.

**“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.

**“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*;

## **DEFINITIONS (Continued)**

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- 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.

“**Late enrollee**” means a person who enrolls under this *Plan* other than on:

- The earliest date on which coverage can become effective under the terms of this plan; or
- A special *enrollment date* for the person as defined by HIPPA.

“**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.

“**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.

“**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 BMI is greater than 40, or 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*.

## **DEFINITIONS (Continued)**

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**“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*.

**“Orthotic appliances”** means braces, splints and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a *covered person’s illness or injury* or improve function; and generally is not useful to a person in the absence of an *illness or injury*.

**“Outpatient”** means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and *room and board charges* are not *incurred*.

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

**“Participating employer(s)”** means City of Stevens Point.

**“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 City of Stevens Point Employee Welfare Benefit Plan.

**“Plan Administrator”** means City of Stevens Point.

**“Plan Document”** means this *Plan Document* and Summary *Plan Description*.

**“Plan Sponsor”** means City of Stevens Point.

**“Plan year”** means the period commencing January 1, 2011 and continuing until the next succeeding anniversary.

**“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 or routine care”** means a prescribed standard procedure that is ordered by a *physician* to evaluate or assist the *covered person’s* health and well-being, screen for possible detection of unrevealed *illness or injury*, improve the *covered person’s* health, or extend the *covered person’s* life expectancy. Generally, a procedure is routine if there is no personal history of the *illness or injury* for which the person is being screened. Benefits included as preventive/routine are listed in the schedule of benefits and will be paid subject to any listed limits or

## **DEFINITIONS (Continued)**

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maximums. Preventive/*routine care* does not include benefits specifically excluded by this plan, or treatment after the diagnosis of an *illness* or *injury*. The HDHP Plan shall include services recommended by the USPSTF.

**“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*.

**“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.

**“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
- It is approved for its stated purpose by *Medicare*.

**“Residential treatment facility”** means an *inpatient* psychiatric facility that provides psychiatric and other therapeutic and clinically informed services to individuals, whose immediate treatment needs require a structured 24 hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual and group therapy, *substance abuse* education/counseling. 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
- It is approved for its stated purpose by *Medicare*

**“Retired person”** means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer’s formal retirement program.

## **DEFINITIONS (Continued)**

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**“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, or more, not including *waiting periods* and affiliation periods, during all of which an individual did not have any *creditable coverage*.

**“Skilled nursing (or extended care) facility”** includes, but is not limited to a *skilled nursing*, rehabilitation, convalescent or sub-acute facility. It is an institution or a designated part of one that is operational pursuant to the law for such an institution and is under the full time supervision of a *physician* or registered nurse. In addition, the plan requires that the facility: Provide 24-hour-a-day service to include *skilled nursing* care and *medically necessary* therapies for the recovery of health or physical strength; is not a place primarily for *custodial care*; requires compensation from its patients; admits patients only upon *physician* orders; has an agreement to have a *physician’s* services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one *hospital* and is licensed by the state in which it operates and provides the services under which the licensure applies.

**“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.

**“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.

**“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;

## **DEFINITIONS (Continued)**

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- Obstetrical delivery and dilation and curettage; or
- Biopsy.

**“Third party administrator”** means Security Administrative Services.

**“Temporomandibular Joint Disorder (TMJ)”** shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

**“Total disability”** or **“totally disabled”** means the inability of an *employee* to perform the duties of any occupation for which he or she may be qualified by reason of training, education or experience. In the case of a *dependent* it means the substantial inability of the *dependent* to engage in the normal activities of an individual of the same age and sex. The *Plan Administrator* may, in its sole discretion, require satisfactory evidence of *total disability*.

**“Trade Act”** means the *Trade Act* of 2002, as amended.

**“Transitional care”** means services for the treatment of nervous or *mental disorders*, or *substance abuse* that are directly provided to a *covered person* in a less restrictive manner than are *inpatient hospital* services but in a more intensive manner than are *outpatient* services.

**“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 and reasonable”** or **“usual, customary and reasonable fees”** (“UCR”) means services and supplies which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the *Plan Administrator*, taking into consideration:

- The fee which the *provider* most frequently charges the majority of patients for the service or supply;
- The prevailing range of fees charged in the same Area by *providers* of similar training and experience for the service or supply; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

“Area” means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of *providers* rendering such services or furnishing such supplies.

**“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.

**“You, Your”** means the *employee*.

## **PLAN ADMINISTRATION**

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

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 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.

### **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*.

## **PLAN ADMINISTRATION (Continued)**

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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. 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.

### **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*.

### **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*;

## **MISCELLANEOUS INFORMATION (Continued)**

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- 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 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.

## MISCELLANEOUS INFORMATION (Continued)

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**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

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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*;

## HIPAA PRIVACY PRACTICES (Continued)

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- 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 not 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:

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: City Attorney Human Resource Manager Comptroller-Treasurer

- 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

## **HIPAA PRIVACY PRACTICES (Continued)**

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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*.