

**Amendment to the
Summary Plan Description for
Dunn County Employee Medical Plan
HSA Medical Option**

**Amendment #1 to the
2013 Restated Summary Plan Description**

This Amendment is hereby made a part of the *Summary Plan Description (SPD)*, is effective January 1, 2014, and is as follows:

1. The following new subsections entitled “*Routine Patient Costs Associated with Clinical Trials*” and “*Essential Health Benefits Benchmark*” are hereby added at the end of Section IV. **Introduction to Your Coverage**, as follows:

Routine Patient Costs Associated with Clinical Trials

The *Plan* covers *routine patient costs* associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of *routine patient costs* for items and services furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial*.

If one or more *providers* are participating in a *clinical trial*, the *Plan* will cover *routine patient costs* only if *you* participate in the *clinical trial* through a *participating provider* and if the *provider* will accept *you* in the *clinical trial*. This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. However, the *Plan* will not cover *routine patient costs* if *you* are in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider benefits*.

Essential Health Benefits Benchmark

Employer acknowledges and agrees that, to the extent required by the *Affordable Care Act*, the *essential health benefits* of Wisconsin benchmark apply to the *Plan*.

2. All references to “pre-existing condition exclusion” and/or “pre-existing condition limitation” contained in Section I. **Rights of Covered Persons**, Section V. **B. Enrollment and Effective Date**, Section IX. **Leaves of Absence**, and Section XIX. **Definitions of Terms Used** are hereby deleted in their entirety.
3. Subsection V. **C. Pre-Existing Condition Limitation** is hereby deleted in its entirety.
4. Section V. is retitled “**Eligibility, Enrollment, and Effective Date**” and all references to this section in the provisions of the *SPD* are adjusted accordingly.
5. Section VI. **Benefit Maximums** is deleted in its entirety and replaced with the following:

Benefit Maximums

Annual Benefit Maximum

Unlimited.

Lifetime Benefit Maximum

Unlimited.

6. The following exclusions, wherever used in the *SPD*, are hereby deleted:

Mental health or substance use related conditions that according to generally accepted professional standards cannot be improved with treatment, except as stated in this *SPD*.

Developmental mental disabilities or mental conditions that, according to generally accepted professional standards, are not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.

7. The *Preventive Health Care Services* subsection is deleted and replaced with the following:

Preventive Health Care Services

The *Plan* covers preventive services mandated under the *Affordable Care Act* (ACA) that you receive during the *calendar year*. These services and their frequency and time frames are stated in the ACA Preventive Health Care Services Schedule (“ACA Schedule”). The ACA Schedule may be amended, from time to time, on a prospective basis, and is available on the *TPA*’s member website or by contacting Customer Service.

Examples of services on the ACA Schedule include:

- Counseling for certain conditions.
- Immunizations.
- Laboratory tests, pathology and radiology.
- Routine physical examinations.
- Prenatal screenings.
- Screenings for certain cancers and certain other conditions.

100% of *eligible charges*.
Deductible does not apply.

100% of *eligible charges*.
Deductible does not apply.

Preventive services that are not required by the *Affordable Care Act*, but that are covered by the *Plan*:

- Routine eye examinations

100% of *eligible charges*.
Deductible does not apply.

100% of *eligible charges*.
Deductible does not apply.

- Routine hearing examinations

100% of *eligible charges*.
Deductible does not apply.

100% of *eligible charges*.
Deductible does not apply.

- Routine prenatal care exams and one routine postnatal exam.

100% of *eligible charges*.
Deductible does not apply.

100% of *eligible charges*.
Deductible does not apply.

• Child health supervision services*.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.
• Screening for lead poisoning up to age 6.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.

Female *covered persons* may obtain annual preventive health examinations and prenatal screenings from obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician* or prior approval from the *Plan*.

*Child health supervision services includes pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six and appropriate immunizations from ages six to 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Exclusions:

- Please see the section entitled “Exclusions.”
- Any service performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in this section of the *SPD*.
- All *non-preventive health care services* are not covered under this section of the *SPD*.

8. The **O. Physical Therapy, Occupational Therapy and Speech Therapy** subsection is deleted and replaced with the following:

O. Physical Therapy, Occupational Therapy and Speech Therapy	Coverage is limited to maximum of eight visits per <i>covered person</i> per <i>calendar year</i> for sensory integration therapy for the treatment of feeding disorders. Additional visits may be covered if prior authorized and determined to be <i>medically necessary</i> by the <i>Plan</i> .	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .

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

Coverage for Autism Spectrum Disorder. Autism spectrum disorder means any of the following:

1. Autism Disorder;
2. Asperger’s Syndrome; or
3. Pervasive Developmental Disorder not otherwise specified.

Coverage will be provided for intensive and non-intensive level services that are:

1. prescribed by a *physician* and provided by providers as defined in Wisconsin Administrative Code 3.36 (3) (f) through (m), and

2. approved by the Federal Food and Drug Administration, if the treatment is subject to the approval of the Federal Food and Drug Administration, and
3. medically and scientifically accepted evidence clearly demonstrates that the treatment meets all of the following criteria:
 - a. the treatment is proven safe.
 - b. the treatment can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the *covered person*.
 - c. the treatment meets the coverage terms of the *Plan* and is not specifically excluded under the terms of the *Plan*.

Intensive level services for:

1. evidence-based therapies to address cognitive, social and behavioral conditions, and
2. a minimum of 30 to 35 hours of care per week for a duration of up to 4 years, and
3. individuals between 2 to 9 years of age.

Non-intensive level services are 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.

The *Plan* may require confirmation of the primary diagnosis by the *physician*.

Exclusions:

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

9. The exclusion for "*Investigative* procedures, clinical trials and associated expenses" in Section **VII. Exclusions, 3.** is deleted and replaced with the following:

Investigative procedures and associated expenses.

10. The following exclusions are hereby added to Section **VII. Exclusions:**

Routine eye examinations, except as covered under this *SPD*.

Routine hearing examinations, except as covered under this *SPD*.

Costs associated with *clinical trials* that are not *routine patient costs*.

11. Paragraph 2. of subsection **XIII. C. Order of Benefit Determination Rules** is deleted and replaced with the following:

2. **Child Covered Under More Than One Plan:** The order of benefits when a child is covered by more than one plan is:

- a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
 - The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.

For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a of this section as if those persons were parents of such child.

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is the plan of the:
- Custodial parent;
 - Spouse of the custodial parent;
 - Noncustodial parent; and then
 - Spouse of the noncustodial parent.
- d. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent's spouse.

12. Section **XVI. Internal Appeal and External Review Processes** is deleted in its entirety and replaced by the following:

XVI. Claim Appeals Process

Internal Appeals Process

The internal review process for an appeal of a *claim* that is wholly or partially denied and for a rescission (retroactive termination) of *your* coverage, as defined by the *Affordable Care Act*, is:

1. Acute Care Services Appeals

If *your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to the *TPA* in writing, by telephone, or electronically, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* appeal to the *Plan Administrator* for its decision.

As quickly as *your* medical condition requires, but no later than 72 hours of receipt of *your* appeal by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree.

2. Non-Acute Care Services Appeals

- a. **First Appeal.** If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate.

Within 15 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it, references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.

- b. **Second Appeal.** Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 15 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree.

3. Concurrent Care Claims

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

4. Post-Service Appeals

- a. **First Appeal.** If *your* post-service *claim* for *benefits* is wholly or partially denied, *you* or *your* authorized representative may submit an appeal within 180 calendar days after receiving notice that *your claim* is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information as appropriate.

Within 30 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.

- b. **Second Appeal.** Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 30 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

5. Access to Relevant Documents

Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your* appeal. If the *Plan Administrator* or the *TPA* generates, relies upon, or considers any new or additional evidence in connection with the appeal, or identifies any new or additional rationale for a denial, it will be provided to *you* so that *you* have a reasonable opportunity to respond. *You* have the right to present written evidence and testimony as part of the appeals process.

External Review Process

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act*, or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*, *you* may have a right to have such decision reviewed by an independent review organization that is not associated with the *TPA*, *Plan* or *Plan Administrator*. The decision of the independent review organization is binding except to the extent other remedies may be available to the *Plan*, any person, or any entity under state or federal law. The following sections relating to Standard External Review and Expedited External Review apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act* or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*:

1. **Standard External Review.** *You* may request an external review of any pre-service request or post-service *claim* based on medical judgment if *you* have exhausted all appeals available to *you* under the internal appeals process. Any denial, reduction, or termination of, or failure to provide payment for, a *benefit* based on a determination that *you* failed to meet the requirements for eligibility under the terms of the *Plan* is not eligible for external review. Within four months after receiving a notice informing *you* of *your* right to an external review by an independent review organization, *you* or *your* authorized representative may submit a written request for an external review with an independent review organization by sending it to the *TPA*. When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision.

Within one business day after completion of a preliminary review, which may take up to five business days, to confirm whether *you* were enrolled properly in the *Plan* at the time the pre-service *claim* was requested or post-service *claim* was provided, the *TPA* will notify *you* that *your* request is:

- Complete and eligible for external review; or
- Not complete, and will indicate what additional information or materials are needed to make it complete; or
- Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for external review, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

2. **Expedited External Review.** *You* may request an expedited external review if:
 - a. *Your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services, or *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, and the timeframe for completion of an expedited internal appeal would seriously jeopardize *your* life, health, or ability to regain maximum function.

Nevertheless, *you* must have filed a request for an expedited internal appeal in order to request an expedited external review; or

- b. *You* exhausted the internal appeals process and *you* have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize *your* life, health, or ability to regain maximum function; or
- c. *You* exhausted the internal appeals process for coverage that involves an admission, availability of care, continued stay or health care item or service for which *you* received *emergency* services but have not been discharged from a facility.

When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. Immediately upon receipt of *your* request for an expedited external review, the *TPA* will make a determination and notify *you* that *your* request is:

- Complete and eligible for external review; or
- Not complete, and will indicate what information or materials are needed to make it complete; or
- Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for the external review process, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

13. The definitions of “*Coinsurance*”, “*Non-Participating Provider*” and “*Participating Provider*” in Section XIX. **Definitions of Terms Used** are deleted and replaced by the following:

Coinsurance A portion of *eligible charges* that is paid by *you* and a separate portion that is paid by the *Plan* for *covered services* and supplies. *Your coinsurance* is a percentage of those *eligible charges* that are the (1) discounted charges that are negotiated with the *participating provider* and calculated at the time the *claim* is processed; or (2) *usual and customary amount*.

Non-Participating Provider A clinic, *physician, provider, facility* that is licensed but is not a *participating provider*.

Participating Provider A licensed clinic, *physician, provider* or facility that is directly contracted to participate in the specific *TPA participating provider* network designated by *Plan Administrator* to provide benefits to *covered persons* enrolled in this *SPD*. The participating status of *providers* may change from time to time.

Participating providers may also be offered from other Preferred Provider Organizations that have contracted with *TPA*.

14. The following four definitions are added to Section XIX. **Definitions of Terms Used:**

Affordable Care Act The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.

Clinical Trial

A phase I, phase II, phase III, or phase IV *clinical trial* that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - a. National Institutes of Health.
 - b. Centers for Disease Control and Prevention.
 - c. Agency for Health Care Research and Quality.
 - d. Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in paragraphs a through d above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Essential Health Benefits

The categories of services that qualified health plans are required to cover, as defined and required by the *Affordable Care Act*. The *benefits* covered by this *SPD* may include some *essential health benefits*, but this *SPD* is not and is not intended to be a qualified health plan and does not, and is not required to, cover all *essential health benefits*.

Routine Patient Costs

The cost of any *covered services* that would typically be covered if *you* were not enrolled in an approved *clinical trial*. *Routine patient costs* do not include:

1. the cost of the investigational item, device, or service that is the subject of the approved *clinical trial*.
2. items and services provided solely to satisfy data collection and analysis needs and not used in direct clinical management.
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

This Amendment does not change, alter, or amend any of the other provisions or limitations of the *SPD*.

