

SUMMARY PLAN DESCRIPTION

**DUNN COUNTY
HSA MEDICAL OPTION**

PreferredOne[®]
ADMINISTRATIVE SERVICES

PKA20225

JANUARY 2013

<p>Questions?</p>	<p>PreferredOne Administrative Services, Inc. Customer Service staff is available to answer questions about <i>your</i> coverage.</p> <p>When contacting Customer Service, please have <i>your</i> identification card available. If <i>your</i> questions involve a bill, we will need to know the date of service, type of service, the name of the <i>provider</i>, and the charges involved.</p>						
<p>PreferredOne Administrative Services, Inc.</p> <p>Telephone Numbers for Pre-certification and Pre-Service/Concurrent Care <i>Claims</i></p>	<p>Monday through Friday 7 AM to 7 PM Central Time</p> <table border="0"> <tr> <td>Customer Service</td> <td>763.847.4477</td> </tr> <tr> <td>Toll free</td> <td>1.800.997.1750</td> </tr> <tr> <td>Hearing impaired individuals</td> <td>763.847.4013</td> </tr> </table>	Customer Service	763.847.4477	Toll free	1.800.997.1750	Hearing impaired individuals	763.847.4013
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Hearing impaired individuals	763.847.4013						
<p>Website</p>	<p>www.preferredone.com www.healtheos.com</p>						
<p>Mailing Address</p>	<p><i>Claims</i>, appeal requests, pre-certification, and written inquiries should be mailed to:</p> <p>Customer Service Department PreferredOne Administrative Services, Inc. P.O. Box 59212 Minneapolis, MN 55459-0212</p>						

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I. Rights of Covered Persons

The *Plan*, as defined in Section II. *Your Employer (Plan Administrator)*, includes one or more health *benefit* options, which may have different eligibility requirements and/or *benefits*. If a different *Summary Plan Description (SPD)*, *SPD* option, provision or amendment applies to certain *benefit* options or classifications of individuals eligible under the *Plan*, you will be furnished a copy of the *SPD*, *SPD* option, provision or amendment that is applicable to you. This *SPD* applies only to the HSA medical option and the eligible employees enrolled for participation in this option of the *Plan*.

Continue Group Health Plan Coverage

- Continue health care coverage for *yourself* and/or *your covered dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* or *your covered dependents* may have to pay for such coverage.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under *your* group health plan, if *you* have *creditable coverage* from another plan. *You* should be provided a certification of *creditable coverage*, free of charge, from *your* group health plan or health insurance issuer when *you* lose coverage, when *you* become entitled to elect COBRA continuation coverage, when *your* COBRA continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, *you* may be subject to a pre-existing condition exclusion for 18 months after *your enrollment date* in *your* group health plan.

II. Your Employer (Plan Administrator)

Your Employer, which also serves as the *Plan Sponsor* and the *Plan Administrator*, has established an Employee Medical Plan (the *Plan*) to provide health care *benefits*. This *Plan* is “self-insured” which means that the *Plan Sponsor* pays the *claims* from its own assets for *covered services*. The HSA medical option of this *Plan* is described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Plan*. *Your Employer* has contracted with *PreferredOne* to provide *claim* processing, pre-certification and other administrative services. However, *your Employer* is solely responsible for payment of *your* eligible *claims*.

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

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

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

III. PreferredOne Administrative Services, Inc. (PreferredOne, TPA)

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

IV. Introduction to *Your* Coverage

A. *Summary Plan Description (SPD)*

This *Summary Plan Description (SPD)* is *your* description of the HSA medical option of the *Plan Sponsor's Plan*. **Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the *Plan*.** The *SPD* describes the *Plan's benefits* and limitations for *your* health care coverage. Included in this *SPD* is a *Benefit Schedule* that states the amount payable for the *covered services*. *Benefits* are not covered for excluded services, and exclusions include, but are not limited to, health care services that are not *medically necessary* as determined by the *Plan Administrator*. Be sure to review the list of exclusions as well as the *Benefit Schedule*. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. *Benefits* are not available for *medically necessary* services, unless such services are also *covered services*. ***Benefits are limited to the most cost effective and medically necessary alternative.*** The *Plan Administrator* has, to the fullest extent permitted by law, the sole, final and exclusive discretion to determine *benefits* available under the *Plan*.

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

B. Administrative Services Agreement

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

C. Identification Cards

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

D. Designated Website or *Provider* Directory

You may find *participating providers* on the designated website listed on the inside cover of this *SPD*. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes and the *TPA* does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that a *provider* *you* choose is a *participating provider* by calling Customer Service at the telephone number listed on the inside cover of this *SPD*. *Provider* directories are available to *you* upon request.

E. For Non-Emergency Services Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs services for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers*, will be covered at the *participating provider* level of *benefits* as shown in the "*Benefit Schedule*."

If a *non-participating provider* arranges or performs services for *you* at a *participating facility*, all related eligible non-facility charges from any *non-participating providers* will be covered at the *non-participating provider* level of *benefits* as described in the "*Benefit Schedule*." *You* will be responsible for any charges that may exceed the *usual and customary amount*.

F. Case Management

In cases where *your* condition is expected to be or is of a serious nature, the *TPA* may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the *Plan*.

Under certain conditions, the *Plan Administrator* will consider other care, services, supplies, reimbursement of expenses, or payments of *your* serious *sickness* or *injury* that would not normally be covered or would only be partially covered. The *Plan Administrator* and *your physician* will determine whether any medical care, treatments, services or supplies will be covered. Such care, treatment, services, supplies, reimbursable expenses, or payments will not be considered as setting any precedent or creating any future liability, with respect to *you*, or any other *covered person*.

G. Conflict with Existing Law

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

H. Privacy

This *Plan* is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rules. In accordance with the HIPAA Privacy Rules, the *Plan* and the *TPA* acting on the *Plan's* behalf, maintains, uses, or discloses *your* Protected Health Information for things like *claims* processing, utilization review, quality assessment, case management, and otherwise as necessary to administer the *Plan*. *You* can obtain a copy of the *Plan's* Notice of Privacy Practices (which summarizes the *Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how the *Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Plan Administrator*.

I. Processing Delays, Fraud, Misrepresentation, Rescission and Right to Audit

If routine processing delays occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under the *Plan* for which *you* are not eligible under the *Plan*. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination except where required by law. It is *your* responsibility to confirm the accuracy of statements made by the *Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and other plan documents. *Your* coverage may not be retroactively terminated unless *you* request it or *you* (or someone acting on *your* behalf) falsifies information, submits fraudulent, altered or duplicate billings, allows another person not covered under the *Plan* to use *your* coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*. Notwithstanding, *you* may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *contributions*.

Determination of *your* coverage will be made at the time a *claim* is reviewed. In addition, the *Plan Administrator* may require *you* to furnish proof of *your* eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *contributions* and the coverage provided under the *Plan*. If the *Plan Administrator* determines that, after reasonable requests, *you* have failed to provide adequate records or sufficient proof of *your* eligibility status, the *Plan Administrator* may, in its sole discretion, rescind or terminate *your* coverage to the extent permitted by law.

J. Limited Access to Participating Providers

In the event that the *Plan Administrator* determines *you* are receiving health care services and supplies or *prescription drugs* in a quantity or manner that might be harmful to *your* health, the *Plan Administrator* will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician*, *hospital* and pharmacy to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, the *Plan Administrator* will choose for *you*.

Failure to receive health care services and supplies through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers*, *you* must obtain a written referral from *your* selected participating *physician*.

K. Limited Access to *Participating Providers*

In the event that the *Plan Administrator* determines *you* are receiving health care services and supplies or *prescription drugs* in a quantity or manner that might be harmful to *your* health, the *Plan Administrator* will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician, hospital* and pharmacy to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, the *Plan Administrator* will choose for *you*.

Failure to receive health care services and supplies through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers, you* must obtain a written referral from *your* selected participating *physician*.

L. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your benefits* and coverage under this *SPD*, including coverage examples, that is prepared in a uniform style. If there is a conflict between this *SPD* and the SBC, this *SPD* governs and the *TPA* will administer your coverage in accordance with this *SPD*.

V. Eligibility, Enrollment, and *Effective Date* and Pre-Existing Condition Limitation

A. Eligibility

To be eligible to enroll for coverage, *you* must be:

1. Classified by the *Plan Sponsor* as a full-time or 80% employee regularly scheduled to work a minimum of 32 hours per week; or part-time employee working less than 32 hours a week.
2. Employees/early retirees who retire from the county at age 55 or at age 50 if in protective services may continue to participate until such time as the former employee/early retiree or his/her spouse becomes eligible for Medicare, whichever occurs later.
3. Eligible management employees who leave service may continue to participate until such time as the former employee or his/her spouse becomes eligible for Medicare, whichever occurs later.
4. A dependent of the employee. An employee must enroll for coverage in order to enroll his or her dependents. If both parents are covered as employees, a child may be covered as a dependent of either or both parents.

Eligible dependents include a *covered employee's*:

1. Lawful spouse of the opposite sex and does not include a common law spouse regardless if recognized under other state or country law.
2. Children, from birth through age 25, including:
 - a. Natural children;
 - b. Legally adopted children or children placed with *covered employee* for legal adoption. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support;
 - c. Stepchildren;
 - d. unmarried grandchildren who reside in *your* home in an on-going parent/child relationship that is intended to continue until their parent, *your covered dependent* reaches age 18, and are dependent on *you* for a majority of their financial support and are claimed as income tax dependents on *your* federal income tax return. After the parent of *your* grandchildren reaches age 18, the grandchildren must be placed in *your* legal custody;
 - e. A child who is under the age of 26 and for whom *covered employee* has been appointed legal guardian by a court of law;
 - f. A child covered under a valid Qualified Medical Child Support Order (QMCSO), which is enforceable against an eligible employee. Contact the *Plan Administrator* for assistance in obtaining information, at no cost to *you*, regarding the procedures governing QMCSO determinations. The *Plan Administrator* is responsible for determining whether or not a medical child support order is a valid QMCSO.

3. Children who are age 27 or more when discharged from the military and who are enrolled as students in regular full-time attendance at an accredited secondary or post-secondary educational institution as recognized by the U.S. Secretary of Education, which is an accredited high school, university, four-year college, community college, technical school, or vocational school. In order to qualify as an eligible dependent under this provision:
 - a. The student must carry the required number of credits per quarter/semester to qualify as a full-time student, as defined by the educational institution; and
 - b. The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.

Notwithstanding the provisions set forth in paragraph 3. above, a *covered dependent* shall be able to continue coverage from the date of a medically necessary leave of absence or change in student enrollment until the earliest of the date that is: 1) one year after the first day of such leave of absence or change in student enrollment; 2) the date on which such leave of absence or change in student enrollment is no longer medically necessary; or 3) the date on which coverage would otherwise end under the terms of the *Plan* (e.g., upon attaining the maximum age) if he/she:

- a. is a full-time student in a post-secondary accredited school and enrolled in the *Plan* on the day before a medically necessary leave of absence or change in student enrollment starts;
 - b. takes the leave of absence or makes a change to student enrollment as a result of a serious illness or injury that the attending physician certifies is medically necessary; and
 - c. loses full-time student status as a result of the medically necessary leave of absence or change in student enrollment.
4. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 31 calendar days after the dependent child reaches age 26. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* may request proof again each year. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this *Plan* and if he/she meets all of the following criteria:
 - a. Became disabled before age 26;
 - b. Was a *covered dependent* under the *Plan* prior to reaching age 26;
 - c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
 - d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
 - e. Is unmarried.

If the dependent child is disabled and 26 years of age or older at the time of the *covered employee's* enrollment in this *Plan*, the *covered employee* may enroll the dependent child if within 31 calendar days after the *covered employee's* initial enrollment in this *Plan* the *covered employee* provides the *Plan* with proof that such dependent child meets all of the following requirements:

- a. Became disabled before age 26;
- b. Received health coverage through the *covered employee* within the 60-day period immediately preceding the *covered employee's* enrollment for coverage under this *Plan*;
- c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
- d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
- e. Is unmarried.

B. Enrollment and Effective Date

New Enrollment. The eligible employee must make written application to enroll him/herself and any eligible dependents and pay any required *contribution*, within 31 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first day of the month coinciding with or immediately following a 30-day *waiting period*. Not subject to any pre-existing condition limitations.

Annual Enrollment. Subject to all eligibility, enrollment and the pre-existing condition limitations as described in the Pre-Existing Condition Limitation section if age 19 or older, the employee may enroll himself or herself and his or her eligible dependents during the Employer's annual enrollment period. Coverage is effective the first day of the *calendar year*.

Late Enrollment. If the employee does not enroll within 31 calendar days of the date the employee first becomes eligible, the employee may enroll at any time along with his/her eligible dependents. Coverage will be effective the first day of the month following a 30-day *waiting period* coinciding with or immediately following the date the *Plan* receives the application for coverage subject to any applicable pre-existing condition limitation as described in the Pre-Existing Condition Limitation section.

Rehires/Layoffs. If an employee person was previously covered by this *Plan* and is rehired within 6 months after termination of employment and the employee's written application for coverage is received by the *Plan* before becoming eligible or within 31 days after becoming eligible, coverage will take effect on the first day of the month coinciding with or immediately following a 30-day *waiting period* from the employee's date of hire. Not subject to a pre-existing condition limitation.

Part-time to Full-time Employment with Employer: *Your* coverage will be effective on the first day of the month following a 30-day *waiting period* from the employee's date of becoming a full-time employee.

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

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

Coverage will be effective on the date of the event described in paragraph 3.a. or 3.b. above provided the *Plan* receives the application for coverage as required. Not subject to any pre-existing condition limitations.

Special Enrollment Period for Covered Persons due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

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

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

Special Enrollment Period for Medicaid and Children’s Health Insurance Program (CHIP) Participants.

If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid plan or a state CHIP and that coverage is terminated as a result of loss of eligibility, then the eligible employee may request enrollment in the *Plan* on behalf of him/herself and/or his/her eligible dependents. Such request must be made within 60 days of the date the employee’s and/or his/her dependent’s coverage is terminated from such state plans.

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

Coverage will be effective the date other coverage is terminated provided the *Plan* receives the application for coverage as required. Not subject to any pre-existing condition limitations.

C. Pre-Existing Condition Limitation

Pre-existing condition limitation means that a pre-existing condition is not covered until the end of 18 months from the *enrollment date* if you are considered a *late enrollee*.

A pre-existing condition is any condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received, during the six-month period immediately preceding *your enrollment date*. Pregnancy is not considered a pre-existing condition. The *Plan Administrator* cannot request, require, or purchase genetic information prior to, or in connection with, *your* enrollment in the *Plan*.

The 18-month pre-existing condition limitation periods are reduced by any period of time during which *you* had *continuous* and *creditable coverage* prior to enrollment under this *Plan*. If *you* are not considered a *late enrollee*, any *waiting period* is not considered a break in coverage.

This pre-existing condition limitation does not apply to *covered persons* who are under age 19. In addition, this pre-existing condition limitation does not apply to a *covered employee’s* adopted children or to children placed for adoption with *covered employee* who are timely enrolled under a special enrollment due to adoption under the “Special Enrollment Period for *Covered Persons* Due to the Acquisition of New Dependents” section of this *SPD*.

VI. Benefit Schedule

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

Discounts negotiated by the *TPA* with *providers* may affect your *coinsurance* amount. This *Plan* may pay higher *benefits* if you choose a *participating provider*. If you use a *non-participating provider*, in addition to any *deductibles* and *coinsurance*, you pay all charges that exceed the *usual and customary amount*.

A. Pre-certification Requirement and Prior Authorization

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

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

Provision	Participating Provider	Non-Participating Provider
Pre-certification Penalty	None.	<i>Plan</i> payment is reduced by \$500 per service per <i>covered person</i> .

Pre-certification through the *Plan Administrator* is required. Failure to obtain pre-certification may result in a reduction of *benefits* based on the pre-certification penalty listed above:

- All non-emergency inpatient admissions including *skilled nursing facility*, rehabilitation, *hospital*, etc.;
- *Transplant services*; and
- Hospice.

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

Prior Authorization: It is recommended that you or your *provider* request in advance that certain services be authorized as *medically necessary* in advance by the *Plan Administrator*. Pre-certification penalties do not apply. You should follow the same procedures for prior authorization as you follow for pre-certification with respect to obtaining services and submitting an appeal. If you have questions about prior authorization, please contact Customer Service.

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

- Drugs or procedures that may be *cosmetic*;
- Phase III investigational drugs for the treatment of HIV;
- Drugs or procedures that may be *investigative*;
- Durable medical equipment (DME) and prosthesis that may exceed \$5,000;
- Non-emergency transportation;
- Outpatient surgeries;
- Physical therapy, occupational therapy, speech therapy and other therapies; and
- Pain therapy programs.

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

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

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

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

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

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

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

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

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

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

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

Note: Refer to the subsection entitled “Internal appeal and External Review Process” for details on requesting an appeal or external review.

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

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

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

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

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

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

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

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

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

Note: Refer to the subsection entitled “Internal appeal and External Review Process” for details on requesting an appeal or external review.

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

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

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

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

Procedure for Concurrent Care Claims

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

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

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

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

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

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

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

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

Note: Refer to the section entitled "Internal Appeal and External Review Processes" for details on requesting an appeal or external review.

B. Medical Audit Bonus

Your Employer offers a medical audit bonus program as an incentive to all *covered employees* to encourage examination and self-auditing of eligible provider medical charges to ensure the amount billed by a *provider* accurately reflects the services and supplies received by the *covered person*. The Employer's medical audit bonus program is offered outside of this *Plan* and separately administered by *your Employer*. The Employer's medical audit bonus program is not part of the *Plan* and not paid or funded with *Plan* funds. The *covered employee* is asked to review all provider medical charges and verify that each itemized service has been received and that the provider's bill does not represent either an overcharge or a charge for services never received. This self-auditing procedure is strictly voluntary; however, it is to the advantage of the *Plan* as well as the *covered employees* to avoid unnecessary payment of health care costs.

In the event a self-audit of a provider charge results in elimination or reduction of provider charges, 50% of the amount eliminated will be paid directly by the Employer under the medical audit bonus program to the *covered employee* (subject to a \$500 maximum payment per occurrence) less applicable payroll taxes and deductions, provided the saving are accurately documented and satisfactory evidence of a reduction in provider charges is submitted to the Employer (e.g., a copy of the incorrect bill and a copy of the corrected billing). Note that federal/state income tax laws may treat this payment as taxable compensation to the *covered employee*, subject to applicable payroll tax withholding and reporting.

This self-audit bonus is separate from, but in addition to, the payment of all other applicable *Plan benefits* for *eligible charges*.

This bonus will not be payable for expenses in excess of the *usual and customary charges* or expenses which are not covered under *Plan*, regardless of whether the charges are or are not reduced.

C. Deductible, Out-of-Pocket Limit and Benefit Maximums

NOTE: Your coverage is either “covered employee only” or “family.” Therefore, only one of the following sections (“Covered employee only” or “Family”) applies to you. If you have questions about which section applies to you, contact TPA or your employer.

Covered Employee Only

Deductible: The covered employee must first satisfy the deductible amount by incurring charges equal to that amount for eligible services in a calendar year before the Plan will pay benefits. Copies of bills for eligible services used to satisfy the deductible must be submitted to the Plan. The Plan will not pay benefits for the eligible charges applied toward the deductible. Pre-certification penalties and any amount in excess of the usual and customary amount will not apply towards satisfaction of the deductible. The covered employee will not be required to satisfy the deductible before the Plan will pay benefits for the following: preventive health care services from participating providers.

Out-of-Pocket Limit: After the covered employee has met the out-of-pocket limit per calendar year for coinsurance and deductibles, Plan covers the charges incurred for all other eligible charges. The covered employee pays any amounts greater than the out-of-pocket limit if any benefit maximums are exceeded. It is the covered employee's responsibility to demonstrate to the Plan the coinsurance and deductibles in excess of this amount have been paid in any calendar year, and to pay any amounts greater than the out-of-pocket limits if any benefit maximums are exceeded. Expenses paid for any amount in excess of the usual and customary amount will not apply towards satisfaction of the out-of-pocket limit. The cost differential between a brand-name drug and a generic drug does not apply to the out-of-pocket limit if you request a brand-name drug when an equivalent generic drug is available.

Annual Benefit Maximum: The annual benefit maximum is the cumulative amount per covered person for all eligible charges while covered under any and all plans, or options providing health care benefits offered by the Employer.

Covered Employee Only	Participating Providers	Non-Participating Providers
Deductible		
The deductible for services received from participating providers and non-participating providers is combined.		
	\$1,250 per covered person per calendar year.	\$1,500 per covered person per calendar year.
Out-of-Pocket Limit		
The out-of-pocket limit for services received from participating providers and non-participating providers is combined.		
	\$1,250 per covered person per calendar year.	\$1,500 per covered person per calendar year.
Benefit Maximums		
Annual Benefit Maximum	\$2,000,000 for all services.	
Lifetime Benefit Maximum	Unlimited.	

Family (Covered Employee and Covered Dependents)

Family Deductible: The family must first satisfy the family deductible amount by incurring charges equal to that amount for eligible services in a calendar year before the Plan will pay benefits. Copies of bills for eligible services used to satisfy the family deductible must be submitted to the Plan. The Plan will not pay benefits for the eligible charges applied toward the family deductible. Pre-certification penalties and any amount in excess of the usual and customary amount will not apply towards satisfaction of the family deductible. Covered persons of the family will not be required to satisfy the family deductible before the Plan will pay benefits for the following: preventive health care services from participating providers.

Family Out-of-Pocket Limit: After the family has met the family out-of-pocket limit per calendar year for coinsurance and family deductibles, the Plan covers the charges incurred for all other eligible charges. The family must pay any amounts greater than the family out-of-pocket limit if any benefit maximums are exceeded. It is the family's responsibility to demonstrate to the Plan the coinsurance and family deductibles in excess of this amount have been paid in any calendar year, and to pay any amounts greater than the family out-of-pocket limit if any benefit maximums are exceeded. Expenses paid for any amount in excess of the usual and customary amount will not apply towards satisfaction of the family out-of-pocket limit. The cost differential between a brand-name drug and a generic drug does not apply to the out-of-pocket limit if you request a brand-name drug when an equivalent generic drug is available.

Annual Benefit Maximum: The annual benefit maximum is the cumulative amount per covered person for all eligible charges while covered under any and all plans, or options providing health care benefits offered by the Employer.

Family (Covered Employee and Covered Dependents)	Participating Providers	Non-Participating Providers
Family Deductible	The deductible for services received from participating providers and non-participating providers is combined.	
	\$2,800 per family per calendar year.	\$3,400 per family per calendar year.
Family Out-of-Pocket Limit	The out-of-pocket limit for services received from participating providers and non-participating providers is combined.	
	\$2,800 per family per calendar year.	\$3,400 per family per calendar year.
Benefit Maximums		
Annual Benefit Maximum	\$2,000,000 per covered person for all services.	
Lifetime Benefit Maximum	Unlimited.	

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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D. Ambulance Services

100% of <i>eligible charges</i> after the <i>deductible</i> .	Same as the <i>Participating Provider Plan Payment</i> .
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The *Plan* covers ambulance service to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance transport to the nearest *hospital* that is able to render *medically necessary* care, is covered only when the condition is an acute medical *emergency* and is authorized by a *physician*.

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

Prior authorization is suggested for:

- non-emergency ambulance service, from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted; and
- non-emergency transfers by ambulance from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests when medical supervision is required en route.

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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E. Chiropractic Services

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

Exclusions:

- Please see the section entitled “Exclusions.”
- Routine maintenance chiropractic care.
- Blood, urine or hair analysis related to chiropractic services.
- Ultrasound, MRI, EMG, waveform, and nuclear medicine diagnostic studies related to chiropractic services.
- Manipulation under anesthesia related to chiropractic services.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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F. Dental Services

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

100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
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Accidental Dental Services. Treatment and repair for services required due to an accidental *injury* must be completed within 12 months from the date of the *injury*. The *Plan* covers services to treat and restore damage done to a sound, natural tooth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss.

Medically Necessary Dental Services. The *Plan* covers dental services, limited to dental services required for treatment of an underlying medical condition, e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions. The *Plan* also covers surgical extraction of impacted wisdom teeth.

Dental Implants: This *Plan* covers dental implants and/or any associated procedures, *prosthetics* or supplies resulting from but not limited to gingival musosal surgery to treat gingivitis or periodontitis.

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

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> . NOTE: <i>Non-participating providers</i> must have a Medicare provider number for their charges to be eligible for coverage.
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G. Durable Medical Equipment (DME), Services, and Prosthetics

Hearing aids, devices to improve hearing and related fittings, for children under age eighteen and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.

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

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

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

Exclusions:

- Please see the section entitled “Exclusions.”
- Any durable medical equipment or supplies not listed as eligible on the *Plan’s* durable medical list, or as determined by the *Plan Administrator*.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
- Duplicate or similar items.
- Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation.
- Hearing aids, devices to improve hearing and related fittings except for once in a three year period for children under age eighteen and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts and car carrier.
- Over-the-counter orthotics and appliances.
- Custom molded foot orthotics.
- Wigs for any reason.
- Orthopedic shoes, except for covered persons with diabetes or peripheral vascular disease.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the *Plan Administrator* determines are not eligible for coverage.
- Charges for sales tax, mailing or delivery.

- Durable medical equipment, orthotics, and prosthetics that are necessary for activities beyond activities of daily living (ADL's).
- Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i> <i>Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.</i>
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H. Emergency Room Services

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

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

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

Covered *hospital* services are subject to all of the *benefit* limitations set forth in this *SPD*. Notify Customer Service of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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I. Home Health Services

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

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

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

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

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

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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J. Hospice Care

100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
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The *Plan* covers hospice services for terminally ill patients in a hospice program. The patient must meet the eligibility requirements of the program and elect to receive services through the hospice program. The services will be provided in the patient’s home or hospice center, with inpatient care available when *medically necessary*. Hospice services are in lieu of curative or restorative treatment.

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

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

You may withdraw from the hospice program at any time.

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

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

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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K. Hospital Services

Outpatient Hospital Services, Ambulatory Care or Surgical Facility, or Birthing Center Services	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
Outpatient Hospital, Partial Hospital, and Rehabilitation Services in a Day Hospital Program for Mental and Substance Use Related Disorders	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
Inpatient Hospital and Birthing Center Services	If you have <i>covered employee</i> only coverage, on the date of birth of a newborn, you and your new <i>covered dependent(s)</i> become subject to the terms and conditions of family coverage.	
	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
Inpatient Hospital and Licensed Residential Treatment Facility Services for Mental and Substance Use Related Disorders	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .

Notify Customer Service of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

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

- Use of operating rooms or other outpatient departments, rooms or facilities;
- General nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, (unless replaced) and other diagnostic or treatment related outpatient services;
- Mental health and substance use related disorder services, such as:
 - An initial court-ordered exam for a *covered dependent* age 18 and under;
 - Outpatient professional services for evaluation and diagnostic services, crisis intervention, therapeutic services including psychiatric services and treatment of mental and nervous conditions;
 - Diagnosis and treatment of substance-related conditions including evaluations, diagnostic services, therapeutic services and psychiatric services;
 - Outpatient individual and group therapy;
 - Outpatient family therapy that is recommended by a designated *provider* treating a minor *covered dependent* child;
 - Medication management.
- Laboratory tests, pathology and radiology;
- *Physician* and other professional medical and surgical services rendered while an outpatient; and
- Nutritional counseling for weight management, except as otherwise covered under the *Preventive Health Care Services* section of this *SPD*.

Medically necessary genetic testing determined by *TPA* to be *covered services* if it is determined that: 1) the *covered person* displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of the test will directly impact the current treatment being delivered to the *covered person*; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The *Plan* also covers *preventive health care services*. These preventive services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD*.

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

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

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

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

The *Plan Administrator* must receive a copy of any court order and evaluation. The *Plan Administrator* may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or health issuer may pay for a shorter stay if the attending *provider* (e.g., *your physician*, nurse midwife, or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans or health issuers may not set the level of *benefits* or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health issuer may not, under federal law, require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *providers* or facilities, or to reduce *your* out-of-pocket costs, *you* may be required to obtain pre-certification as described in the pre-certification provisions of the *Benefit Schedule*.

Exclusions:

- Please see the section entitled “Exclusions.”
- Travel, transportation, other than ambulance transportation, or living expenses, except as provided in this *SPD*.
- Hospitalization, transportation, supplies, or medical services, including *physicians’* services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
- Nutritional counseling, except when:
 1. Provided during a *confinement*; or
 2. Provided in a *physician’s* office, clinic system or *hospital* setting:
 - i. For the diagnosis and treatment of diabetes; or
 - ii. For the diagnosis of an eating disorder; or
 - iii. For treatment of an eating disorder by an eating disorder treatment program; or
 - iv. To a *covered person* who has been diagnosed by a *physician* with a chronic medical condition; or
 - v. As counseling that is treated as a *preventive health care service*.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Non-emergency ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
- Services and/or drugs to treat conditions that are *cosmetic* in nature.
- Orthoptics.
- Refractive surgery (e.g. lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Services, drugs, and/or surgery and associated expenses for gender reassignment.
- Genetic testing and associated services, except as provided in this *SPD*.
- Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Autopsies, unless requested by the *Plan Administrator*.
- Cochlear implants to improve hearing and related fittings, except for once in a three year period for children under age eighteen and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
- Marital counseling, relationship counseling, family counseling except as otherwise described in this *SPD*, or other similar counseling or training services.
- 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.
- Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
- Counseling, studies, services or *confinements* ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator*.
- Treatment of compulsive gambling.
- Nutritional and food supplements.
- Weight loss programs, including, but not limited to, consultations, laboratory services, testing, and weight loss drugs, except when treated as a *preventive health care service*.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.
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L. Infertility Services

Diagnostic Services Only

See "Office Visits" and
"Hospital Services."

See "Office Visits" and
"Hospital Services."

This *Plan* covers only the professional services necessary to diagnose infertility and the related tests, facility charges, and laboratory work related to eligible services. **Services for the treatment of infertility are not eligible for coverage under this *Plan*.**

Exclusions:

- Please see the section entitled "Exclusions."
- All services related to the treatment of infertility.
- Artificially assisted technology such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
- In vitro fertilization.
- Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
- Surrogate pregnancy.
- Sperm banking.
- Embryo and egg storage.
- Reversal of voluntary sterilization.
- Donor egg or sperm.
- *Prescription drugs*, including oral, implantable and injectable drugs for infertility.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.
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M. Office Visits

Sickness or Injury	Coverage for <i>medically necessary</i> genetic testing is limited to once per lifetime of the <i>covered person</i> if determined by the <i>TPA</i> to be <i>covered services</i> , as described below.	
<ul style="list-style-type: none"> • Nutritional counseling for weight management, except as otherwise covered under the <i>Preventive Health Care Services</i> section. • Port wine stain removal • Diabetic education • Oral surgery in <i>physician's</i> office • Lab, pathology and x-ray • Diabetic education except as otherwise covered under the <i>Preventive Health Care Services</i> section. • Oral surgery in <i>physician's</i> office • Lead Poisoning Blood Tests (for children under age 6) • Vision Therapy 	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
Temporomandibular Disorder (TMD) <ul style="list-style-type: none"> • Surgical Services • Office visits • Physical therapy • Splints 	100% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<ul style="list-style-type: none"> • Eyeglass and contact lenses - (excluding frames) 	100% of billed charges after the <i>deductible</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> every 2 consecutive <i>calendar years</i> .	
Web Based Care	100% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Designated Convenience Care Center	100% of <i>eligible charges</i> after the <i>deductible</i> .	Not applicable.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
Urgent Care Center	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 office visits and *urgent care center* and *designated convenience care center* visits related to diagnosis, care, or treatment of medical, mental health, and substance use related conditions, *sickness*, or *injury*:

- Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, and treatment of mental and nervous disorders; and
- Diagnosis and treatment of substance use related disorders, including evaluation, diagnosis, therapy and psychiatric services.
- Laboratory tests, pathology and radiology.
- Allergy injections.
- Contact lenses prescribed as *medically necessary* for the treatment of keratoconus. The lenses and fitting are *eligible charges* under the Durable Medical Equipment (DME) *benefit*. *Covered persons* must pay for lens replacement.
- Surgical service performed during an office visit.
- Oral surgery is covered for: (a) treatment of oral neoplasm and non-dental cysts; (b) fracture of the jaws; and (c) trauma to the mouth and jaws.
- Treatment of confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD). Dental services required to directly treat TMD or CMD are eligible with the exception of orthodontic services. . TMD splints are *eligible charges* under the Durable Medical Equipment (DME) *benefit*.
- Treatment of cleft lip and cleft palate for a covered *dependent* child. Treatment must be scheduled or have started prior to the covered *dependent* child reaching age 19. Treatment includes orthodontic treatment and oral surgery directly related to the cleft. Dental services required for the treatment of cleft lip or cleft palate are covered. If a covered *dependent* child is also covered under a dental plan, which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.
- Port wine stain treatment to lighten or remove the coloration.
- Diabetic outpatient self-management training and *educational* services.
- An *emergency* examination of a child ordered by judicial authorities.
- Testing for HIV related conditions and drugs.
- Eyeglass and contact lenses, and their related fittings, excluding eyeglass frames.
- Vision therapy.

The *Plan* also covers *preventive health care services*. These preventive services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD*.

Exclusions:

- Please see the section entitled “Exclusions.”
- Services, seminars, or programs that are primarily *educational* in nature.
- Health education, except when:
 1. Provided during an office visit for *non-preventive health care services*; or
 2. It is counseling which is treated as a *preventive health care service*.
- Smoking cessation programs, except when it is treated as counseling which is a *preventive health care service*.
- Nutritional counseling, except when:
 1. Provided during a *confinement*; or
 2. Provided in a *physician's* office, clinic system or *hospital* setting:
 - i. For the diagnosis and treatment of diabetes; or
 - ii. For the diagnosis of an eating disorder; or
 - iii. For treatment of an eating disorder by an eating disorder treatment program; or
 - iv. To a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
 - v. As counseling that is treated as a *preventive health care service*.
- Recreational therapy.
- Professional sign language and foreign language interpreter services in a *provider's* office.
- Exams, other evaluations, and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or as *preventive health care services*.
- Charges for duplicating and obtaining medical records from *non-participating providers*, unless requested by the *Plan Administrator*.
- Genetic testing and associated services, except as provided in this *SPD*.
- Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Treatment of cleft lip and cleft palate for a *covered person* age 18 and over.
- Audiologist services not provided in an office setting.
- Marital counseling, relationship counseling, family counseling except as otherwise described in this *SPD*, or other similar counseling or training services.
- 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.
- *Biofeedback*.
- Weight loss programs, including, but not limited to, consultations, laboratory services, testing, and weight loss drugs, except when treated as a *preventive health care service*.
- Eyeglass frames.
- Orthodontic services to treat CMD or TMD.
- Diagnosis or treatment of sexual dysfunction or impotence.
- Nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

<i>Benefits</i>	<i>Designated Transplant Network</i>
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**N. Organ and Bone
Marrow Transplant
Services**

See “Hospital Services” and
“Office Visits and Urgent Care Center Visits and
Designated Convenience Care Center Visits”.

The *Plan* covers eligible *transplant services* that are pre-certified and determined by the *Plan Administrator* to be *medically necessary* and not *investigative*. *Transplant services* must be received at a *designated transplant network provider*.

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

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

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

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

Coverage is limited to two transplant procedures under this *Plan* for the same condition per person per lifetime.

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

Exclusions:

- Please see the section entitled “Exclusions.”
- Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures for a condition that is *investigative*.
- Supplies, drugs and aftercare for or related to non-human organ implants.
- Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by the *Plan Administrator*.
- Non-emergency ambulance service from *hospital to hospital* such as transfers and admission to *hospitals* performed only for convenience.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
- Travel expenses including but not limited to lodging and transportation.

<i>Benefits</i>	<i>Participating Provider Plan Payment</i>	<i>Non-Participating Provider Plan Payment</i> <i>Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.</i>
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O. Physical Therapy, Occupational Therapy and Speech Therapy

Coverage is limited to maximum of eight visits per *covered person* per *calendar year* for sensory integration therapy for the treatment of feeding disorders. Additional visits may be covered if prior authorized and determined to be *medically necessary* by the *Plan*.

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

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

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 shall be covered for care up to the consumer price index (CPI) adjusted amount per *covered person* per *calendar year* as stated in Wisconsin statute 632.895 (12m) 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 covered up to the CPI adjusted amount per *covered person* per *calendar year* as stated in Wisconsin statute 632.895 (12m). 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 CPI shall be adjusted annually to reflect changes in the CPI 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 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.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment <i>Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.</i>
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P. Prescription Drug Services

Coverage includes *prescription drugs* dispensed at a pharmacy.

NOTE: This section does not cover or provide benefits for oral, injectable, insertable and *prescription drugs* and devices that are *preventive health care services* described in the “Preventive Contraceptive Methods and Counseling for Women” section of this *SPD*.

With the exception of contraceptive drugs for women, benefits for *specialty drugs* and/or injectable drugs, are as described in this section, regardless of the place of service where the *specialty drug* and/or injectable drug is dispensed or administered.

If *you* request a brand name drug when a generic drug alternative is available, *you* are required to pay the difference in cost between the brand name and the generic drug, in addition to any applicable *coinsurance*.

The difference in cost between the brand name drug and the generic will not apply to the *out-of-pocket limit, deductible or coinsurance* that *you* are responsible for. When *you* have reached the *out-of-pocket limit, you* must still pay for the difference in the cost between the brand name and the generic drug.

- Up to a 30-day supply
- Up to a 30-day supply for one type of insulin
- Prenatal vitamins
- Diabetic supplies: Coverage includes over-the-counter diabetic supplies, including glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary*

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

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
<ul style="list-style-type: none"> • <i>Specialty drugs</i> including blood factors, excluding insulin <ul style="list-style-type: none"> ➤ Up to a 30-day supply ➤ <i>Specialty drugs</i> may be oral or injectable ➤ Must be purchased through a specialty pharmacy ➤ A list of specialty pharmacies may be obtained on the <i>Plan's</i> website or by calling Customer Service ➤ The list of <i>specialty drugs</i> may be revised from time to time without notice • Injectable drugs that are neither <i>specialty drugs</i> nor women's contraceptives, excluding insulin 	100% of <i>eligible charges</i> after the <i>deductible</i> .	100% of <i>eligible charges</i> after the <i>deductible</i> .
<ul style="list-style-type: none"> • Mail order drugs, up to a 90-day supply 	100% of <i>eligible charges</i> after the <i>deductible</i> .	Not applicable.

The *Plan Administrator* uses a *drug formulary* to determine which *prescription drugs*, including generic equivalents are covered. The *formulary* is subject to periodic review and modification. For information, *you* may call the *TPA* at the phone number listed on the inside front cover of this *SPD*.

Compounded drugs will be covered provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the compounded product will be considered for coverage after documented failure of the commercially prepared product(s). A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable *benefit* level will be applied. *Compounded drugs* containing any product that is excluded by the *Plan* will not be covered including dosages and route of administration that have not been approved by the FDA. *Compounded drugs* will be covered according to the *covered person's* pharmacy network *benefits*. If a *non-participating provider* pharmacy is used to obtain the compounded prescription, the *non-participating provider benefits* will apply without exception.

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

- *Specialty drugs*
- Topical and oral - acne medications for *covered persons* age 26 and over.

Exclusions:

- Please see the section entitled “Exclusions.”
- *Compounded drugs* that are being used for bio-identical hormone replacement therapy, unless otherwise covered.
- Replacement of a *prescription drug* due to loss, damage, or theft.
- Certain *combination drugs* and other drugs, regardless of *formulary* status will not be covered according to the *Plan's* pharmacy policy titled “Cost Benefit Program.” Contact Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.
- Over-the-counter drugs with or without a *physician's* prescription.
- Over-the-counter home testing products.
- Drugs not approved by the FDA.
- Take home drugs when dispensed by a *physician*.
- Weight loss drugs.
- *Prescription drugs* and over-the-counter drugs for smoking cessation.
- Prescriptions written by a *dentist*, unless in connection with dental procedures covered under this *Plan*.
- Drugs used for *cosmetic* purposes.
- Unit dose packaging per request of the *covered person*.
- *Prescription drugs* for the treatment of infertility.
- *Prescription drugs* to treat sexual dysfunction.
- *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label use of *specialty drugs*.
- Growth hormone therapy.
- Oral, injectable and insertable contraceptives and contraceptive devices, except as covered as a *preventive health care service* in the Preventive Contraceptive Methods and Counseling for Women section of this *SPD*.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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Q. Preventive Contraceptive Methods and Counseling for Women

The *Plan* covers preventive contraceptive methods and counseling services received during the *calendar year* by female *covered persons* as described in the *Preventive Health Care Services* Schedule.

The Schedule, which includes preventive contraceptive methods and counseling services for women provided by the Affordable Care Act and its accompanying regulations (the “ACA”), is available on the *TPA’s* member website or by calling Customer Service.

The full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women’s contraceptive drugs, devices, and delivery methods obtained from a pharmacy up to a 1-month supply per prescription or refill, mail order pharmacy up to a 90-day supply per prescription or refill, or received at a *physician’s* office:

- Generic and Brand oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law.
- Sterilization procedures, excluding the reversal of sterilization procedures.
- *Covered person* education and counseling about contraceptive methods.

100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply. Mail order: not applicable.
100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> after the <i>deductible</i> .
100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	100% of <i>eligible charges</i> after the <i>deductible</i> .

If *you* request a brand name women’s contraceptive that requires a prescription under applicable law when a generic alternative is available, *you* are required to pay the difference in cost between the brand name and the generic contraceptive, in addition to any applicable *coinsurance*.

The difference in cost between the brand name contraceptive and the generic will not apply to the *out-of-pocket limit*, *deductible* or to any *coinsurance* that *you* are responsible for. When *you* have reached the *out-of-pocket limit*, *you* must still pay for the difference in the cost between the brand name and the generic contraceptive.

Exclusions:

- Please see the section entitled “Exclusions.”
- Abortifacient drugs are not covered under this section of this *SPD*.
- Abortions are not covered under this section of this *SPD*.
- Over-the-counter contraceptives, including condoms, spermicides, and drugs such as the “morning after pill.”
- Hysterectomies are not covered under this section of this *SPD*.
- Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair are not covered under this section of this *SPD*.
- Reversal of sterilization procedures.
- All non-*preventive health care services* are not covered under this section of this *SPD*.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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R. Preventive Health Care Services

The Plan covers *Preventive Health Care Services* that you receive during the *calendar year* as described in the *Preventive Health Care Services Schedule* and according to the frequency and time frames stated in the Schedule. The 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.

The Schedule includes the *preventive health care services* provided by the ACA, which includes such routine services as:

- Counseling for certain conditions.
- Eye and hearing examinations.
- Immunizations, including flu shots when ordered by a *physician* or if not ordered by a *physician*, then provided by a *participating provider* inside or outside of a primary care setting.
- Laboratory tests, pathology and radiology.
- Physical examinations when ordered by a *physician*.
- Periodic prenatal exams.
- Child health supervision services.
- Screenings for certain cancers (such as colonoscopy, mammogram, Pap test, PSA test) and certain other conditions (such as abdominal aortic aneurysm, diabetes, HIV and osteoporosis).

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

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

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

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*.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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S. Reconstructive Surgery

See “Hospital Services” and “Office Visits and <i>Urgent Care Center Visits</i> and <i>Designated Convenience Care Center Visits</i> ”.	See “Hospital Services” and “Office Visits and <i>Urgent Care Center Visits</i> and <i>Designated Convenience Care Center Visits</i> ”.
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The *Plan* covers *medically necessary reconstructive surgery* due to *sickness*, accident or congenital anomaly. *Eligible charges* include eligible *hospital, physician, laboratory, pathology, radiology* and facility charges. Contact Customer Service to determine if a specific procedure is covered.

Reconstructive surgery following a mastectomy includes the following:

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

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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**T. Skilled Nursing
Facility Services**

Coverage is limited to a maximum of 30 days
per covered person per calendar year.

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

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

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

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

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

Exclusions:

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

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment Note: For <i>non-participating providers</i> , in addition to any <i>deductibles</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>usual and customary amount</i> .
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U. Weight-Loss Benefit

See “Hospital Services”, “Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits”, and “Preventive Health Care Services” sections of this SPD.	See “Hospital Services”, “Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits”, and “Preventive Health Care Services” sections of this SPD.
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The *Plan* covers *physician* and *dietician* services and *hospital/clinical* programs for weight loss treatment of obesity if they are *preventive services*, or if:

- you have had a Body Mass Index (BMI) that has been over 35 for at least 3 years;
- your BMI has decreased by 10.0;
- you maintain your reduced BMI for 6 months; and
- you remain covered under this *Plan* on the date *benefits* would be payable.

Exclusions:

- Please see the section entitled “Exclusions.”
- Food supplements and nutrients.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment <i>Note: For non-participating providers, in addition to any deductibles and coinsurance, you pay all charges that exceed the usual and customary amount.</i>
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V. Wellness Benefit

100% up to \$250 per covered adult.
Deductible does not apply.

Your Employer covers expenses for eligible fitness and wellness programs and services for *you* and *your* dependent spouse that are not otherwise covered under the *Preventive Health Care Services* section. Coverage is limited to a maximum reimbursement of \$250 per covered adult per *calendar year*. Please refer to *your* Employer's list of wellness programs and eligible providers.

Exclusions:

- Please see the section entitled "Exclusions."

VII. Exclusions

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

1. Services or supplies that the *Plan Administrator* determines are not *medically necessary*.
2. Services or supplies received before coverage under this *Plan* begins or after *your* coverage under this *Plan* ends.
3. *Investigative* procedures, clinical trials, and associated expenses.
4. Services or supplies not directly related to *your* care.
5. Services or supplies ordered or rendered by *providers* or para-professionals unlicensed by the appropriate state regulatory agency.
6. Services, drugs, or supplies not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
7. Charges for services determined to be duplicate services by the *Plan Administrator*.
8. Charges that exceed the *usual and customary amount*.
9. Services prohibited by law or regulation, or illegal under applicable laws.
10. Charges for services that are eligible for payment under any insurance policy, including auto insurance, or under a Workers' Compensation law, employer liability law or any similar law.
11. Services that are paid or payable under Medicare Part B but only to the extent *you* are eligible to be covered under Medicare Part B and *you* and/or this *Plan* are not subject to Medicare secondary rules.
12. All services, except emergency services, for *covered persons* when outside the United States.
13. Eyeglasses, frames and their related fittings.
14. Contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.
15. Personal comfort or convenience items.
16. Any service or supply provided by a relative (i.e., a spouse, or a parent, brother, sister, or child of the *covered employee* or of the *covered employee's* spouse) or anyone who customarily lives in the *covered employee's* household.
17. Services provided by certified surgical technicians, certified surgical assistants, first surgical assistants, or orthopedic technicians.
18. Services provided by massage therapists, doulas, and personal trainers.
19. Services of *providers* who have not completed professional level education and licensure as determined by the *Plan*.
20. Sexual devices, services, or supplies, and *prescription drugs* for the treatment of sexual dysfunction, except as otherwise covered in this *SPD*.
21. Erectile dysfunction *prescription drugs*, unless otherwise covered in this *SPD* or approved for other use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

22. Charges for medical services that are paid or payable under any auto insurance policy, which covers the *covered person*, or for which the *covered person* is required by law to enroll.
23. Procedures that are generally *cosmetic*, or for convenience or comfort reasons, as listed on the *Plan's* Cosmetic Procedures Policy. This policy may be obtained by calling Customer Service.
24. Orthognathic surgery.
25. Massage therapy.
26. Telephone consultations.
27. Alternative therapies such as aromatherapy and reflexology.
28. *Vocational rehabilitation*.
29. Drugs, medical devices, or therapies that are approved only for *compassionate use* by the U.S. Food and Drug Administration.
30. Homeopathic medicine, including dietary supplements.
31. Holistic medicine and services.
32. Light-based treatments for acne.
33. Travel, transportation or living expenses.
34. Elective abortion.
35. Acupuncture.
36. Charges billed by *providers* that are not in compliance with generally accepted guidelines established by the Centers for Medicare & Medicaid Services (CMS) and/or the *TPA's* policies.
37. *Sickness* or *injury* that results from:
 - Engaging in an illegal act or the attempt to engage in a felony act. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition, such as alcoholism.
 - Voluntary participation in a riot, insurrection or civil disobedience.
 - War or any act of war. "War" means declared or undeclared war and includes acts of terrorism.

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

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

38. Ambulance Services:
 - See all exclusions.*
 - Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
39. Chiropractic Services:
 - See all exclusions.*
 - Routine maintenance chiropractic care.
 - Blood, urine or hair analysis related to chiropractic services.
 - Ultrasound, MRI, EMG, waveform, and nuclear medicine diagnostic studies related to chiropractic services.
 - Manipulation under anesthesia related to chiropractic services.

40. Dental Services:

- See all exclusions.*
- Dental services covered under *your* dental plan.
- Preventive dental procedures.
- Dental services, orthodontia and all associated expenses, except as stated in this section.
- Services for cracked or broken teeth that result from biting, chewing, disease or decay.
- Dental implants.
- Prescriptions written by a *dentist*, unless in connection with dental procedures covered under this *Plan*.
- Dental services related to periodontal disease.

41. Durable Medical Equipment (DME), Services, and Prosthetics:

- See all exclusions.*
- Any durable medical equipment or supplies not listed as eligible on the *Plan's* durable medical list, or as determined by the *Plan Administrator*.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
- Duplicate or similar items.
- Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation.
- Hearing aids, devices to improve hearing and related fittings (except as provided in the Durable Medical Equipment (DME) Services and Prosthetics schedule).
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts and car carrier.
- Over-the-counter orthotics and appliances.
- Custom molded foot orthotics.
- Wigs for any reason
- Orthopedic shoes except for covered persons with diabetes or peripheral vascular disease.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the *Plan Administrator* determines are not eligible for coverage.
- Charges for sales tax, mailing or delivery.
- Durable medical equipment, orthotics, and prosthetics that are necessary for activities beyond activities of daily living (ADL's).
- Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.

42. Emergency Services:

- See all exclusions.*
- Non-emergency services received in an emergency room.

43. Home Health Services:

- See all exclusions.*
- Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
- Services provided as a substitute for a primary caregiver in the home.
- Services that can be performed by a non-medical person or self-administered.
- Home health aides, unless determined to be *medically necessary* by the *Plan Administrator*.
- Services provided in *your* home for convenience.
- Services provided in *your* home due to lack of transportation.
- *Custodial care*.

- Services at any site other than *your* home.
 - Recreational therapy.
 - Services rendered by *providers* unlicensed or not certified by the appropriate state regulatory agency.
44. Hospice Care:
- See all exclusions.*
 - Services provided by *your* family or a person who shares *your* legal residence.
 - Respite or rest care, except as specifically described in this section.
45. *Hospital Services*:
- See all exclusions.*
 - Travel, transportation, other than ambulance transportation, or living expenses, except as provided in this *SPD*.
 - Hospitalization, transportation, supplies, or medical services, including *physicians'* services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
 - Nutritional counseling, except when:
 1. Provided during a *confinement*; or
 2. Provided in a *physician's* office, clinic system or *hospital* setting:
 - i. For the diagnosis and treatment of diabetes; or
 - ii. For the diagnosis of an eating disorder; or
 - iii. For treatment of an eating disorder by an eating disorder treatment program; or
 - iv. To a *covered person* who has been diagnosed by a *physician* with a chronic medical condition; or
 - v. As counseling that is treated as a *preventive health care service*.
 - Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
 - Non-emergency ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
 - Services and/or drugs to treat conditions that are *cosmetic* in nature.
 - Orthoptics.
 - Refractive surgery (e.g. lasik) for ophthalmic conditions that are correctable by contacts or glasses.
 - Services, drugs, and/or surgery and associated expenses for gender reassignment.
 - Genetic testing and associated services, except as provided in this *SPD*.
 - Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
 - Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
 - Autopsies, unless requested by the *Plan Administrator*.
 - Cochlear implants to improve hearing and related fittings, except for once in a three year period for children under age eighteen and who are certified as deaf or severely hearing impaired by a *physician* or by a licensed audiologist.
 - Marital counseling, relationship counseling, family counseling except as otherwise described in this *SPD*, or other similar counseling or training services.
 - 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.
 - Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
 - Counseling, studies, services or *confinements* ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator*.
 - Treatment of compulsive gambling.
 - Nutritional and food supplements.
 - Weight loss programs, including, but not limited to, consultations, laboratory services, testing, and weight loss drugs, except when treated as a *preventive health care service*.
 - Surgical treatments and procedures to treat one-sided deafness.
 - Growth hormone therapy.

46. Infertility Services:

- See all exclusions.*
- All services related to the treatment of infertility.
- Artificially assisted technology such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
- In vitro fertilization.
- Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
- Surrogate pregnancy.
- Sperm banking.
- Embryo and egg storage.
- Reversal of voluntary sterilization.
- Donor egg or sperm.
- *Prescription drugs*, including oral, implantable and injectable drugs for infertility.

47. Office Visits:

- See all exclusions.*
- Services, seminars, or programs that are primarily *educational* in nature.
- Health education, except when:
 1. Provided during an office visit for non-*preventive health care services*; or
 2. it is counseling which is treated as a *preventive health care service*.
- Smoking cessation programs, except when it is treated as counseling which is a *preventive health care service*.
- Nutritional counseling, except when:
 1. Provided during a *confinement*; or
 2. Provided in a *physician's* office, clinic system or *hospital* setting:
 - i. For the diagnosis and treatment of diabetes; or
 - ii. For the diagnosis of an eating disorder; or
 - iii. For treatment of an eating disorder by an eating disorder treatment program; or
 - iv. To a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
 - v. As counseling that is treated as a *preventive health care service*.
- Recreational therapy.
- Professional sign language and foreign language interpreter services in a *provider's* office.
- Exams, other evaluations, and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or as *preventive health care services*.
- Charges for duplicating and obtaining medical records from *non-participating providers*, unless requested by the *Plan Administrator*.
- Genetic testing and associated services, except as provided in this *SPD*.
- Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- Treatment of cleft lip and cleft palate for a *covered person* age 18 and over.
- Audiologist services not provided in an office setting.
- Marital counseling, relationship counseling, family counseling except as otherwise described in this *SPD*, or other similar counseling or training services.
- 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.
- *Biofeedback*.
- Weight loss programs, including, but not limited to, consultations, laboratory services, testing, and weight loss drugs, except when treated as a *preventive health care service*.
- Eyeglass frames.
- Orthodontic services to treat CMD or TMD.
- Diagnosis or treatment of sexual dysfunction or impotence.
- Nutritional and food supplements.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy.

48. Organ and Bone Marrow *Transplant Services*:

- See all exclusions.*
- Services related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures for a condition that is *investigative*.
- Supplies, drugs and aftercare for or related to non-human organ implants.
- Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by the *Plan Administrator*.
- Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
- Travel services including but not limited to lodging and transportation.

49. Physical Therapy, Occupational Therapy and Speech Therapy:

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

50. *Prescription Drug Services*

- See all exclusions.*
- *Compounded drugs* that are being used for bio-identical hormone replacement therapy, unless otherwise covered.
- Replacement of a *prescription drug* due to loss, damage, or theft.
- Certain *combination drugs* and other drugs, regardless of *formulary* status will not be covered according to the *Plan's* pharmacy policy titled "Cost Benefit Program." Contact Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.
- Over-the-counter drugs with or without a *physician's* prescription.
- Over-the-counter home testing products.
- Drugs not approved by the FDA.
- Take home drugs when dispensed by a *physician*.
- Weight loss drugs.
- *Prescription drugs* and over-the-counter drugs for smoking cessation.
- Prescriptions written by a *dentist*, unless in connection with dental procedures covered under this *Plan*.
- Drugs used for *cosmetic* purposes.
- Unit dose packaging per request of the *covered person*.
- *Prescription drugs* for the treatment of infertility.
- *Prescription drugs* to treat sexual dysfunction.
- *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label use of *specialty drugs*.
- Growth hormone therapy.

- Oral, injectable and insertable contraceptives and contraceptive devices, except as covered as a *preventive health care service* in the Preventive Contraceptive Methods and Counseling for Women section of this *SPD*.
51. Preventive Contraceptive Methods and Counseling for Women
- See all exclusions.*
 - Abortifacient drugs are not covered under this section of this *SPD*.
 - Abortions are not covered under this section of this *SPD*.
 - Over-the-counter contraceptives, including condoms, spermicides, and drugs such as the “morning after pill.”
 - Hysterectomies are not covered under this section of this *SPD*.
 - Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair are not covered under this section of this *SPD*.
 - Reversal of sterilization procedures.
 - All non-*preventive health care services* are not covered under this section of this *SPD*.
52. *Preventive Health Care Services*
- See all 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*.
53. *Reconstructive Surgery*:
- See all exclusions.*
 - Services and/or drugs to treat conditions that are *cosmetic* in nature.
54. *Skilled Nursing Facility Care*:
- See all exclusions.*
 - Hospitalization, transportation, supplies, or medical services, including *physicians’* services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
 - Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
 - Respite or *custodial care*.
55. Specified *Non-Participating Provider Services*:
- See all exclusions.*
56. *Weight Loss Benefit*:
- See all exclusions.*
 - Food supplements and nutrients.
57. *Wellness Benefit*:
- See all exclusions.*

VIII. Ending *Your* Coverage

Your coverage will terminate on the **earliest of the following dates:**

- The date the *Plan* is terminated;
- The end of the month in which the *covered employee* retires and if retiree is age 65;
- The end of the month in which the early retiree or the retiree's dependent spouse turns age 65, whichever is later.
- The end of the month in which *your* eligibility under the *Plan* ends;
- The end of the month in which *your* written request to cancel coverage is received; unless the *covered employee's* premium payments are paid on a pre-tax basis, as pre-tax premium payments can only cease when certain change in status events occur;
- When *you* do not make *your* required *contribution* for coverage under the *Plan*. Termination will be retroactive to the last day for which *your* required *contribution* has been timely received; or
- The date *you*, or someone acting on *your* behalf, have performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*.

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

IX. Leaves of Absence

A. Family and Medical Leave Act (FMLA)

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

If *you* do not return after an approved absence as described in the preceding paragraph, coverage may be continued under the "COBRA Continuation Coverage" section for a period of up to 18 months, provided *you* elect to continue under that provision.

Immediately following the expiration of *your* FMLA leave, if *you* continue *your* coverage under COBRA, and then return to work with *your* Employer, *you* will not be required to satisfy the *waiting period* or the pre-existing condition limitation, provided that *you* return to work either prior to, or at the end of *your* COBRA coverage and that *you* have no lapse in coverage.

Immediately following the expiration of *your* FMLA leave, if *you* do not continue *your* coverage under COBRA, resulting in a lapse of coverage, and then return to work with *your* Employer, *you* will be subject to the *waiting period* and pre-existing condition limitation.

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

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

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

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

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

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

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

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

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

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

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

X. COBRA Continuation Coverage

The *covered employee*, his/her covered spouse and covered dependent children may continue coverage under the *Plan* when a qualifying event occurs. *You* may elect COBRA for *yourself* regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

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

Your Employer has contracted with a third party COBRA Administrator to provide COBRA continuation administration services on behalf of the *Plan* and the *Plan Administrator*. For general information about *your* rights and obligations under the *Plan* and/or federal COBRA law, *you* should contact the Employer, which is the official *Plan Administrator*. For specific information pertaining to federal COBRA law and *your* rights and obligations under COBRA, *you* should contact the *Plan's* designated COBRA Administrator. For COBRA notice requirements and submission information refer to the appropriate portions of this section.

The *Plan's* designated COBRA Administrator is:

Name: Employee Benefits Corporation
Department: COBRA
Address: PO Box 44347
Madison, WI 53744-4347
Phone #: 1.800.346.2126 Ext: 247

Qualifying Events

1. Loss of coverage under this *Plan* by the *covered employee* due to one of these events:
 - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
 - b. Reduction in the hours of employment of the *covered employee*.
 - c. Layoff of the *covered employee*.
 - d. Leave of absence of the *covered employee*.
 - e. Early retirement of the *covered employee*.
 - f. Total disability of the *covered employee*.
2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
 - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
 - b. Reduction in the hours of employment of the *covered employee*.
 - c. Layoff of the *covered employee*.
 - d. Leave of absence of the *covered employee*.
 - e. Early retirement of the *covered employee*.
 - f. *Covered employee* becoming entitled to Medicare.
 - g. Divorce or legal separation of the *covered employee*.
 - h. Death of the *covered employee*.
 - i. Total disability of the *covered employee*.
3. Loss of coverage under this *Plan* by the *covered dependent* child due to his/her loss of "dependent child" status under this *Plan*.
4. Loss of coverage under this *Plan* due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, his/her covered spouse and covered dependent children.

Required Procedures

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

What the *Plan Administrator* must do:

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

What *You* must do:

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

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

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

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

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

A. Social Security Disability:

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

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

All written notices required for COBRA for a Social Security disability extension must be sent to the designated COBRA Administrator at the following address:

Name: Employee Benefits Corporation
Department: COBRA
Address: PO Box 44347
Madison, WI 53744-4347

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

B. Second Qualifying Events for Covered Dependents Only:

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

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

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

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

All written notices required for COBRA for a Social Security disability extension must be sent to the designated COBRA Administrator at the following address:

Name: Employee Benefits Corporation
Department: COBRA
Address: PO Box 44347
Madison, WI 53744-4347

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

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

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

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

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

CONTINUATION CHART

If coverage under this <i>Plan</i> is lost because this happens...	Who is eligible to continue...	Coverage may be continued until the earliest of: a) the date coverage would otherwise end under the <i>Plan</i> ; or b) the end of the month in which the earliest of the following applicable events occurs:
The <i>covered employee's</i> leave of absence, early retirement, hours were reduced, layoff, or his/her employment with the Employer ended for reasons other than gross misconduct.	<i>Covered employee</i> , covered spouse and covered dependent children	<ul style="list-style-type: none"> • 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>. • Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.
<p>Death of the <i>covered employee</i>.</p> <p>Divorce or legal separation from the <i>covered employee</i>.</p> <p>Entitlement of the <i>covered employee</i> to Medicare within 18 months before the <i>covered employee's</i> hours were reduced or termination of employment for reasons other than gross misconduct.</p> <p><i>Covered person</i> must provide notice of such event in accordance with the <i>Plan's</i> notice procedures previously described for such events.</p>	Covered spouse and covered dependent children	<ul style="list-style-type: none"> • 36 months after continuation coverage began. • 36 months after entitlement of <i>covered employee</i> to Medicare but only for an event which is the <i>covered employee's</i> Medicare entitlement within 18 months before his/her hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>. • Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.
<p>Loss of eligibility by a <i>covered dependent child</i>.</p> <p><i>Covered person</i> must provide notice of such event in accordance with the <i>Plan's</i> notice procedures previously described for such events.</p>	Covered dependent child	<ul style="list-style-type: none"> • 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>. • Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered retiree, covered spouse and covered dependent children	<ul style="list-style-type: none"> • Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered spouse and covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>.
<p>The <i>covered employee</i>, covered spouse or <i>covered dependent child</i> is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the <i>covered employee's</i> leave of absence, early retirement, reduction in hours, layoff, or his/her termination of employment with the Employer for reasons other than gross misconduct.</p> <p>Notice of such disability must be provided by the <i>covered person</i> in accordance with the <i>Plan's</i> notice procedures previously described for COBRA extensions due to Social Security disability.</p>	<i>Covered employee</i> , covered spouse and covered dependent children	<ul style="list-style-type: none"> • 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that <i>covered employee</i>, covered spouse or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the <i>Plan</i>. • Entitlement, after COBRA is elected under the <i>Plan</i>, of the applicable <i>covered person</i> to either Part A or Part B or both Parts of Medicare.

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

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

Special Rule for Pre-Existing Conditions

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

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

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

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

Written Notices Required for COBRA Continuation

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

XII. Subrogation and Reimbursement

Subrogation

For the purposes of this section, “subrogation” means *Plan’s* right to allocate risk in accord with Minnesota Statutes 62A.095 and 62A.096 so that *your* medical claims are ultimately paid by the party that should rightfully bear the burden of the loss.

1. *Plan* is subrogated to any and all claims and causes of action that may arise against any person, corporation, and/or other entity and any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, liability insurance policies, homeowners liability insurance coverage, medical malpractice insurance coverage, patient compensation fund, and any applicable umbrella insurance coverage or other insurance or funds.
2. *Plan’s* subrogation interest is the reasonable cash value of any benefits received by *you*. *Plan’s* subrogation and/or reimbursement interest applies only after *you* have received a full recovery for *your* sickness or injury from another source of compensation for *your* sickness or injury.
3. *Plan’s* right to recover its subrogation interest is subject to a pro rata subtraction for actual monies paid for costs and reasonable attorney fees which shall not exceed the prevailing cost in the same geographical local where the loss arises, and costs *you* pay in obtaining *your* recovery.
4. If the health carrier and *covered person* cannot reach agreement on allocation, the health carrier and *covered person* shall submit the matter to binding arbitration.
5. Nothing in this section shall limit *Plan’s* right to recovery from another source which may otherwise exist at law.

Notice Requirement

You must provide timely written notice to *Plan Administrator* of the pending claim, if *you* make a claim against a third party for damages that include repayment for medical and medically related expenses *incurred* for *your* benefit. Notwithstanding any other law to the contrary, the statute of limitations applicable to *Plan’s* rights for reimbursement or subrogation does not commence to run until the notice has been given.

XIII. Coordination of Benefits

As a *covered person*, you agree to permit the *Plan* to coordinate obligations under this *SPD* with payments under any other health benefit plans as specified below, which cover you as an employee or dependent. You also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. You agree to authorize billing to other health plans for purposes of coordination of benefits.

This *Plan* does not coordinate your *prescription drug benefits* under this *SPD* with any other health plan's *prescription drug* benefits.

Unless applicable law prevents disclosure of the information without the consent of the *covered person* or the *covered person's* representative, each *covered person* claiming *benefits* under this *Plan* must provide any fact needed to pay the *claim*. If the information cannot be disclosed without consent, the *Plan* will not pay *benefits* until the information is given.

A. **APPLICATION:** This Coordination of Benefits provision applies when you have health care coverage under more than one plan. "Plan" is defined below.

B. **DEFINITIONS.** These definitions only apply to the Coordination of Benefits provision:

Allowable Expenses	Means a health care service or expense, including <i>deductibles</i> that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.
Claim Determination Period	Means a calendar year. However, it does not include any part of a year during which a person has no coverage under this <i>Plan</i> , or before the date this Coordination of Benefit provision or a similar provision takes effect.
Closed Panel Plan	Means a plan that provides health benefits to persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits or services provided by other <i>providers</i> , except in cases of <i>emergency</i> or referral by a panel member.
Custodial Parent	Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.
Dependent	A <i>covered employee's</i> eligible dependent as described in the section "Eligibility, Enrollment and <i>Effective Date</i> , and Pre-Existing Condition Limitation" who is enrolled under the <i>Plan</i> .
Plan	Means any of the following that provides benefits or services for medical or dental care or treatment. However, if separate policies are used to provide coordinated coverage for members of any group, the separate policies are considered parts of the same plan and there is no Coordination of Benefits among these policies. <ol style="list-style-type: none">Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured);Hospital indemnity benefits in excess of \$200 per day;Medical care components of group long-term care policies, such as <i>skilled care</i>;A labor-management trustee plan or a union welfare plan;An employer or multi-employer plan or employee benefit plan;Medicare or other governmental benefits, as permitted by law;Insurance required or provided by statute;Medical benefits under group or individual automobile policies;Individual or family insurance for hospital or medical treatment or expenses;

- j. Closed panel or other individual coverage for hospital or medical treatment or expenses.

Plan does not include any:

- a. Amounts of hospital indemnity insurance of \$200 or less per day;
- b. Benefits for non-medical components of group long-term care policies;
- c. School accident-type coverages;
- d. Medicare supplement policies;
- e. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a *claim* had been duly made.

**Primary Plan/
Secondary Plan**

Means the order of benefit determination rules which determine whether this *Plan* is a “primary plan” or “secondary plan” when compared to the other plan covering the person.

When this *Plan* is primary, its *benefits* are determined before those of any other plan and without considering any other plan’s benefits. When this *Plan* is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan’s *benefits*.

- C. ORDER OF BENEFIT DETERMINATION RULES:** The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

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

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

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

1. **Nondependent/Dependent:** The plan that covers the person other than a dependent, for example as an employee, subscriber, or retiree is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

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

- a. Secondary to the plan covering the person as a dependent; and
- b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

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.

- 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.
3. **Active/Inactive Employee:** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.
4. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
- a. The plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan, except for pre-existing conditions under such plan.
 - b. The continuation coverage is the secondary plan, except for pre-existing conditions excluded under the primary plan.
 - c. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.
5. **Longer/Shorter Length of Coverage:** The plan that covered the person as an employee, dependent or retiree for a longer time is primary.
- D. THE EFFECT ON THE BENEFITS OF THIS PLAN:** When this *Plan* is secondary, it may reduce its *benefits*, so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.
- E. RIGHT TO RECEIVE AND RELEASE INFORMATION:** Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine *benefits* payable under this *Plan* and other plans. The *TPA* may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining *benefits* payable under this *Plan* and other plans covering the person claiming *benefits*. The *TPA* need not tell, or get the consent of, any person to do this. Each person claiming *benefits* under this *Plan* must give the *Plan* any facts it needs to apply those rules and determine *benefits* payable.
- F. FACILITY OF PAYMENT:** A payment made under another plan may have included an amount that should have been paid under this *Plan*. If it does, the *Plan* may pay that amount to the organization that made the payment. That amount will then be treated as though it was a *benefit* paid under this *Plan*. The *Plan* will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services. In this case "payment made" means the reasonable cash value of the *benefits* provided in the form of services.
- G. RIGHT OF RECOVERY:** If the *Plan* paid more than it should have paid, it may recover the excess from one or more of the following:
- 1. The person the *Plan* has paid or for whom it has paid; or
 - 2. Any other person or organization that may be responsible for the *benefits* or services provided under this *Plan* to the *covered person*.
- The "amount of payments made" includes the reasonable cash value of any *benefits* provided in the form of services.

H. COORDINATING WITH MEDICARE: This section describes the method of payment if Medicare pays as the primary plan.

If a *provider* has accepted assignment of Medicare, this *Plan* determines allowable expenses based upon the amount allowed by Medicare. This *Plan's* allowable expenses are the lesser of the *usual and customary amount* or the Medicare allowable amount. The *Plan* pays the difference between what Medicare pays and the *Plan's* allowable expenses.

If *you* are eligible for Medicare, *you* will be considered covered for benefits payable under Medicare Part B regardless of whether *you* have applied for Medicare Part B coverage.

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

A. Bills from *Participating Providers*

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

B. Bills from *Non-Participating Providers*

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

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

XV. Initial *Benefit Determinations* of Post-Service *Claims*

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

If *your provider* submits a post-service *claim* on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such *claim* and associated appeals unless *you* specifically direct otherwise to the *TPA* within 10 business days from the *Plan Administrator's* notification that the *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Plan's* filing procedures, provided the *TPA* has all necessary information it needs to make an initial *benefit* determination. Even if the *TPA* has all information it needs to make an initial benefit determination, but determines that an extension is necessary due to matters beyond its control, or the control of any associated group health plan, because it is subject to the requirements of the claims procedures under the U.S. Department of Labor rules at 29 CFR §2560.503-1 et seq. in accordance with the Affordable Care Act, then the *TPA* may extend the time period for its initial benefit determination by sending written notice to *you* before the end of the initial 30 calendar day benefit determination period, which describes the circumstances that require the extension. The *TPA* will notify *you* of its initial determination within 15 calendar days after the end of the initial 30 calendar day benefit determination period.

If the *TPA* does not have all necessary information it needs to make an initial *benefit* determination, then the *TPA* may extend the time period for making the initial benefit determination by sending written notice to *you* before the end of the initial 30 calendar day determination period, which describes the missing information and provides a grace period to *you* for providing the necessary information of at least 45 calendar days from the date *you* receive the notice. The *TPA* will notify *you* of its initial benefit determination within 15 calendar days after the earlier of (i) the date on which the *TPA* receives the requested information and (ii) the end of the specified grace period, if the *TPA* does not receive the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. If, however, *you* or *your* authorized representative submit the requested information after the specified grace period ends and within 365 calendar days after the date *you incurred* services (except in the absence of *your* legal capacity), the *Plan Administrator* may, but is not required to, reconsider the submitted information; and will not consider information it receives more than 365 calendar days after the date *your* services were *incurred*.

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

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

Note: Refer to the subsection entitled “Initial *Benefit* Determination of Post-Service *Claims*” for details on requesting an appeal or external review.

XVI. Internal Appeal and External Review Processes

During any appeal as described below, *your* coverage will remain in force. The *TPA* must be provided all the information needed to make a decision. If the *TPA* does not have all information it needs and cannot obtain complete information from *you* or *your provider* within the time periods set forth below for deciding an appeal, *your* appeal will be denied.

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 a request for the extension 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.

When *you* appeal the initial determination for medical reasons, the *TPA* will arrange for review of the clinical material by a *physician* in the same or similar specialty who did not make the initial determination. As quickly as *your* medical condition requires, but no later than 72 hours of the *TPA*'s receipt of *your* appeal, *you*, *your attending health care professional* and *your attending provider* will receive telephone notice of the *TPA*'s decision, including the specific reasons for it and the procedure for requesting an external review. This time period may be extended if *you* agree. Written notification will be sent to *you*, *your attending health care professional* and *your attending provider* within one business day of the determination, or sooner if *your* medical condition requires.

2. Non-Acute Care Services Appeals

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 extension 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.

When *you* appeal the initial determination for medical reasons, the *TPA* will arrange for review of the clinical material by a physician in the same or similar specialty who did not make the initial determination. Within 30 calendar days after *your* appeal is received by the *TPA*, *you*, *your attending health care professional* and *your attending provider* will receive written notice of the *TPA's* decision, including the specific reasons for it and the procedure for requesting an external review. This time period may be extended for up to an additional 14 calendar days if *you* agree.

3. Concurrent Care Services Appeals

If *your* request for certification extension (concurrent care) 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 services appeals submitted to the *TPA* will be reviewed the same as acute care services appeals above. Non-acute concurrent care services appeals submitted to the *TPA* will be reviewed the same as non-acute care services appeals above.

4. Post-Service Claims Appeals

First Appeal. Within 180 calendar days after receiving notice that *your* post-service *claim* was wholly or partially denied, *you* or *your* authorized representative may submit an appeal. *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 written notice of the *TPA's* decision, including the specific reasons for it and the procedure for requesting a second appeal. This time period may be extended for up to an additional 14 calendar days if *you* agree.

Second Appeal. Within 60 calendar days after receiving 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 requiring a medical determination in its resolution is received by the *Plan Administrator*, *you* will receive written notice of the *Plan Administrator's* decision, including the specific reasons for it and the procedure for requesting an external review. Within 30 calendar days after any other written appeal is received by the *Plan Administrator*, *you* will receive written notice of the *Plan Administrator's* decision and the specific reasons for it. This time period may be extended for up to an additional 14 calendar days 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.

External Review Process

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the Patient Protection and Affordable Care Act of 2010 and its accompanying regulations (the "ACA"), or if *your* coverage is rescinded (retroactively terminated), as defined by the ACA, *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 shall apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the ACA or if *your* coverage is rescinded (retroactively terminated), as defined by the ACA:

1. **Standard External Review.** *You* may request an external review of any pre-service request or post-service *claim* 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.

XVII. If You Have a Complaint

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

You or someone acting on *your* behalf may file a complaint with the Commissioner of Commerce at any time. *You* may reach the Minnesota Department of Commerce at 651.296.2488 within the Twin Cities metropolitan area or by calling 1.800.657.3602 from outside the Twin Cities.

XVIII. No Guarantee of Employment or Overall *Benefits*

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

XIX. Definitions of Terms Used

<i>Acute Care Facility</i>	A facility that provides care to a <i>covered person</i> who is in the acute phase of a <i>sickness</i> or <i>injury</i> and who will have a stay of less than 30 calendar days.
<i>Attending Health Care Professional</i>	The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to a <i>covered person</i> . <i>Attending health care professional</i> shall include only <i>physicians</i> ; chiropractors; dentists; mental health professionals; podiatrists; and advanced practice nurses.
<i>Bariatric Surgery</i>	Surgery related to the treatment of obesity.
<i>Benefits</i>	The health care services or supplies covered under the <i>Plan</i> as approved by the <i>Plan Administrator</i> as <i>covered services</i> , as explained in this <i>SPD</i> and any amendments.
<i>Biofeedback</i>	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
<i>Calendar Year</i>	The 12-month period beginning January 1 and ending the following December 31 for provisions based on a <i>calendar year</i> .
<i>Claim</i>	A request for <i>benefits</i> made by a <i>covered person</i> or his/her authorized representative in accordance with the procedures described in this <i>SPD</i> . It includes pre-certification requests.
<i>Coinsurance</i>	A fixed percentage of <i>eligible charges</i> that is paid by <i>you</i> and a separate fixed percentage that is paid by the <i>Plan</i> to the <i>provider</i> for <i>covered services</i> and supplies. <i>Coinsurance</i> will be based on (1) the discounted charge negotiated between the <i>TPA</i> and <i>participating providers</i> ; or (2) <i>usual and customary amount</i> .
<i>Combination Drug</i>	A <i>prescription drug</i> in which two or more chemical entities are combined into one commercially available dosage form.
<i>Compassionate Use</i>	A method of providing experimental therapeutics prior to final FDA approval for use in humans. This procedure is used with very sick individuals who have no other treatment options. Often, case-by-case approval must be obtained from the FDA for <i>compassionate use</i> of a drug, device, or therapy.
<i>Compounded Drugs</i>	Drugs which are customized drugs prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a <i>physician's</i> specifications to meet an individual patient need.
<i>Confinement</i>	An uninterrupted stay of 24 hours or more in a <i>hospital</i> , <i>skilled nursing facility</i> , rehabilitation facility or <i>licensed residential treatment facility</i> .
<i>Continuous Coverage</i>	The maintenance of <i>continuous</i> and uninterrupted <i>creditable coverage</i> by an eligible employee or <i>dependent</i> . An eligible employee or <i>dependent</i> is considered to have maintained <i>continuous coverage</i> if the individual enrolls in the <i>Plan</i> and the break in <i>creditable coverage</i> is less than 63 calendar days. See <i>waiting period</i> .
<i>Contribution</i>	The payment <i>your</i> Employer requires to be paid on behalf of or for <i>covered persons</i> for the provision of <i>covered services</i> . <i>Your</i> Employer will inform <i>you</i> of <i>your</i> share of the <i>contribution</i> .

<i>Cosmetic</i>	Services, medications and procedures that improve physical appearance but do not correct or improve a physiological function, or are not <i>medically necessary</i> .
<i>Covered Dependent</i>	A <i>covered employee's</i> eligible dependent as described in the section "Eligibility, Enrollment, <i>Effective Date</i> and Pre-existing Condition Limitation" who is enrolled under the <i>Plan</i> .
<i>Covered Employee</i>	The person: <ol style="list-style-type: none"> 1. On whose behalf <i>contribution</i> is paid; and 2. Whose employment is the basis for membership; and 3. Who is enrolled under the <i>Plan</i>.
<i>Covered Person</i>	A <i>covered employee</i> or <i>covered dependent</i> .
<i>Covered Services</i>	Services that are provided by <i>your provider</i> or clinic and are covered by the <i>Plan</i> , subject to all of the terms, conditions, limitations and exclusions of the <i>Plan</i> .
<i>Creditable Coverage</i>	The health benefits or health coverage provided under any of the following: <ol style="list-style-type: none"> 1. Coverage under group health plans (whether or not provided through an insurer); 2. Medicaid; 3. Medicare; 4. Public health plans; 5. National health plans or programs; as well as, 6. All other types of coverage set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
<i>Custodial Care</i>	Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing and feeding.
<i>Day Treatment Services</i>	Any professional or health care services at a <i>hospital</i> or licensed treatment facility for the treatment of mental and substance related conditions.
<i>Deductible</i>	The amount of <i>eligible charges</i> that each <i>covered person</i> must incur in a <i>calendar year</i> before the <i>Plan</i> will pay <i>benefits</i> .
<i>Dentist</i>	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
<i>Designated Convenience Care Center</i>	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
<i>Designated Transplant Network</i>	Any <i>hospital</i> , health care <i>provider</i> , group or association of health care <i>providers</i> that has entered into a contract with or through the <i>TPA</i> to provide organ or bone marrow transplant or stem cell support and all related services and aftercare for a <i>covered person</i> .
<i>Educational</i>	A service or supply: <ol style="list-style-type: none"> 1. Whose primary purpose is to provide training in the activities of daily living, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or 2. That is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending <i>physician</i>.

<i>Effective Date</i>	The date <i>you</i> become eligible for health care services and complete all enrollment requirements, subject to any required <i>waiting period</i> .
<i>Eligible Charges</i>	A charge for health care services and supplies, subject to all of the terms, conditions, limitations and exclusions of the <i>Plan</i> for which the <i>Plan</i> or <i>covered person</i> will pay.
<i>Emergency</i>	<p><i>Emergency</i> services provided after the sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:</p> <ol style="list-style-type: none"> 1. Placing the <i>covered person's</i> health in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
<i>Enrollment Date</i>	The date of <i>your</i> enrollment in the health benefit plan or, if earlier, the first day of the <i>waiting period</i> for enrollment under this <i>Plan</i> .
<i>Fee-for-Service</i>	Method of payment for <i>provider</i> services based on each visit or service rendered.
<i>Fee Schedule</i>	The amount that the <i>participating provider</i> has contractually agreed to accept as reimbursement in full for <i>covered services</i> and supplies. This amount may be less than the <i>provider's</i> usual charge for the service.
<i>Formulary</i>	A list, which may change from time to time, of preferential <i>prescription drugs</i> that is used by the <i>Plan</i> .
<i>Habilitative Therapy</i>	Therapy provided to develop initial functional levels of movement, strength, daily activity or speech.
<i>Homebound</i>	When <i>you</i> are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute <i>homebound</i> status.
<i>Hospital</i>	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of <i>physicians</i> and with 24-hour registered nursing services. The <i>hospital</i> is not mainly a place for rest or <i>custodial care</i> , and is not a nursing home or similar facility.
<i>Incurred</i>	Services and supplies rendered to <i>you</i> . Such expenses shall be considered to have been <i>incurred</i> at the time or date the service or supply was actually purchased or provided.
<i>Injury</i>	Bodily damage other than <i>sickness</i> including all related conditions and recurrent symptoms.
<i>Investigative</i>	<p>As determined by the <i>Plan</i>, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The <i>Plan</i> will consider the following categories of reliable evidence, none of which shall be determinative by itself:</p> <ol style="list-style-type: none"> 1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure the subject of ongoing Phase I, II, or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program (such as National Comprehensive Cancer Network Drugs and Biologics Compendium), as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers*, including whether there are protocols used by the treating facility or another facility, or another facility studying the same drug, device, medical treatment or procedure. In addition to the above, the *Plan* must determine, on a case-by-case basis, that a drug, device or medical treatment or procedure meets the following criteria:
 - a. Reliable evidence preliminarily suggests a high probability of improved outcomes compared to standard treatment (e.g. significantly increased life expectancy or significantly improved function); and
 - b. Reliable evidence suggests conclusively that beneficial effects outweigh any harmful effects; and
 - c. If applicable, the FDA has indicated that approval is pending or likely for its proposed use; and
 - d. Reliable evidence suggests the drug, device or treatment is medically appropriate for the *covered person*.

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

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

Late Enrollee

An eligible employee or dependent who enrolls under the *Plan* other than during:

1. The first period in which the individual is eligible to enroll under the *Plan*; or
2. The special enrollment period; or
3. Paid leave of absence, rehire, layoff or coming from part-time status.

Licensed Residential Treatment Facility

A facility that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, or treatment and is licensed by the Minnesota Commissioner of Human Services and the Minnesota Department of Health for *sickness* related to mental health and substance use.

<i>Medically Necessary/ Medical Necessity</i>	Eligible medical and <i>hospital</i> services that the <i>Plan Administrator</i> determines are appropriate and necessary, and will use its discretion on a case-by-case basis. These services include diagnostic testing, <i>preventive health care services</i> , and other health care services that are appropriate, in terms of type, frequency, level, setting, and duration, for <i>your</i> diagnosis or condition; and the care must: <ol style="list-style-type: none"> 1. Be consistent with the medical standards and generally accepted practice parameters of the medical community; 2. Help restore or maintain <i>your</i> health; 3. Prevent deterioration of <i>your</i> condition; 4. Prevent the reasonably likely onset of a health problem or detect a problem that has no minimal symptoms.
<i>Named Fiduciary</i>	The person or organization that has the authority to control and manage the operation and administration of the <i>Plan</i> . The fiduciary has discretionary authority to determine eligibility for <i>benefits</i> or to construe the terms of the <i>Plan</i> and may delegate such discretion to other individuals or entities.
<i>Non-Participating Provider</i>	A <i>provider</i> not under contract as a <i>participating provider</i> .
<i>Out-of-Pocket Limit</i>	The maximum amount of money <i>you</i> must pay in <i>coinsurance</i> and <i>deductibles</i> before this <i>Plan</i> pays <i>your eligible charges</i> at 100%. If <i>you</i> reach <i>benefit</i> or annual maximums, <i>you</i> are responsible for amounts that exceed the <i>out-of-pocket limit</i> .
<i>Participating Provider</i>	A licensed clinic, <i>physician, provider</i> or facility that is directly contracted to participate in the specific <i>TPA participating provider</i> network designated by <i>Plan Administrator</i> to provide benefits to <i>covered persons</i> enrolled in this <i>SPD</i> . The participating status of <i>providers</i> may change from time to time. <i>Participating providers</i> may also be offered from other Preferred Provider Organizations that have contracted with <i>TPA</i> .
<i>Physical Disability</i>	A condition caused by an <i>injury</i> or congenital defect to one or more parts of the <i>covered person's</i> body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to the <i>Plan</i> and as a result the <i>covered person</i> is incapable of self-sustaining employment and is dependent on the <i>covered employee</i> for a majority of financial support and maintenance. A <i>sickness</i> will not be considered a <i>physical disability</i> .
<i>Physician</i>	A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.) or Doctor of Chiropractic (D.C.).
<i>Plan</i>	The self-insured employee welfare benefit plan, established by the <i>Plan Sponsor</i> for the benefit of <i>covered persons</i> .
<i>Plan Administrator</i>	The entity, that has the exclusive, final and binding discretionary authority to administer the <i>Plan</i> , to make factual determinations, to construe and interpret the terms of the <i>SPD, Plan</i> , and amendments (including ambiguous terms), and to interpret, review, and determine the availability or denial of <i>benefits</i> . The <i>Plan Administrator</i> may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing <i>claims</i> and performing other <i>Plan-connected</i> administrative services.
<i>Plan Sponsor</i>	The entity that establishes and maintains the <i>Plan</i> , has the authority to amend and/or terminate the <i>Plan</i> and is responsible for providing funds for the payment of <i>benefits</i> .

<i>Plan Year</i>	The period following the <i>effective date</i> of the <i>Plan</i> and each subsequent 12-month period this <i>Plan</i> remains in force.
<i>PreferredOne</i>	PreferredOne Administrative Services, Inc., which is a <i>third party administrator (TPA)</i> providing administrative services to <i>your</i> Employer in connection with the operation of the <i>Plan</i> .
<i>Prescription Drug</i>	A drug approved by the Federal Drug Administration for use only as prescribed by a <i>physician</i> .
<i>Preventive Health Care Services</i>	The <i>covered services</i> that are listed and covered in this <i>SPD</i> as shown under the <i>Preventive Health Care Services</i> and/or Preventive Contraceptive Methods and Counseling for Women sections of the <i>Benefit Schedule</i> .
<i>Provider</i>	A health care professional or facility licensed, certified or otherwise qualified under state law to provide health care services.
<i>Reconstructive</i>	<p>Surgery to restore or correct:</p> <ol style="list-style-type: none"> 1. A defective body part when such defect is incidental to or follows surgery resulting from <i>injury, sickness</i>, or other diseases of the involved body part; or 2. A physical defect determined by a <i>physician</i> to have been present at birth and that adversely affects <i>your</i> ability to perform routine activities of daily living; or 3. A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the <i>Plan Administrator</i> to be <i>medically necessary</i>.
<i>Reconstructive Surgery Following a Mastectomy</i>	<p>Coverage for <i>covered persons</i> receiving <i>covered services</i> under the <i>Plan</i> in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy will include:</p> <ol style="list-style-type: none"> 1. reconstruction of the breast on which the mastectomy has been performed; 2. surgery and reconstruction of the other breast to produce symmetrical appearance; 3. prostheses; and 4. treatment of physical complications at all stages of mastectomy, including lymphedema. <p>Services and supplies will be determined in consultation with the attending <i>physician</i> and patient. Such coverage will be subject to <i>coinsurance</i> and other <i>Plan</i> provisions.</p>
<i>Rehabilitative Therapy</i>	Therapy provided to restore functional levels of movement, strength, daily activity or speech after a <i>sickness</i> or <i>injury</i> .
<i>Risk Allowance</i>	A percentage of the reimbursement to a <i>participating provider</i> that is held back, paid or pre-paid, as applicable. The amount withheld, paid or prepaid generally will be less than 20% of the <i>fee schedule</i> amount.
<i>Sickness</i>	Presence of a physical or mental illness or disease.
<i>Skilled Care</i>	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess <i>your</i> changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for <i>skilled care</i> .
<i>Skilled Nursing Facility</i>	A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a <i>hospital</i> swing-bed, and a transitional care unit) that provides <i>skilled care</i> .

<i>Specialist</i>	<i>Providers</i> other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
<i>Specialty Drugs</i>	Injectable and non-injectable <i>prescription drugs</i> having one or more of the following key characteristics: <ol style="list-style-type: none"> 1. Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. Intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. There is limited or exclusive product availability and/or distribution; or there is specialized product handling and/or administration requirements.
<i>Standing referral</i>	A process by which a <i>covered person</i> may access <i>covered services</i> from a <i>specialist</i> for a period of time. The referral is subject to conditions specified in this <i>SPD</i> . The referral must be designated in writing and in advance by the <i>TPA</i> and is only valid for the designated <i>specialist</i> (not to exceed one year).
<i>Summary Plan Description (SPD)</i>	The document describing, among other things, the <i>benefits</i> offered under the HSA medical option of the <i>Plan</i> and <i>your</i> rights and obligations under such <i>benefit</i> option.
<i>Third Party Administrator (TPA)</i>	<i>PreferredOne</i> provides administrative services to the Employer in connection with the operation of the <i>Plan</i> , including processing of <i>claims</i> , as may be delegated to it.
<i>Total Disability</i>	Disability (i.e., due to <i>injury</i> , <i>sickness</i> , or pregnancy) that requires regular care and attendance of a <i>physician</i> , and in the opinion of the <i>physician</i> renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability, and after the first two years of the disability, renders the employee unable to perform the duties of any business or occupation for which he or she was reasonably fitted.
<i>Transplant Services</i>	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
<i>Urgent Care Center</i>	A health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
<i>Usual and Customary Amount</i>	The average amount for each <i>covered service</i> or supply that by discretion of the <i>Plan Administrator</i> is customary in the geographic area in which the service or supply is provided.
<i>Vocational Rehabilitation</i>	Services, supplies or devices for a <i>covered person</i> designed to obtain or regain skills or abilities beyond those activities of daily living, including but not limited to, a device or an enhanced device or service requested or needed to enable the <i>covered person</i> to perform activities for an occupation.
<i>Waiting Period</i>	The period of time that an eligible individual must wait before becoming effective under the <i>Plan</i> . A <i>waiting period</i> will not: (1) apply towards a period of <i>creditable coverage</i> ; or (2) be used in determining a break in <i>continuous</i> and <i>creditable coverage</i> .

Web Based Care

Care provided by designated *participating providers* performed without physical face to face interaction, but through electronic communication allowing evaluation, assessment and the management of services that leads to a treatment plan provided by a *participating provider* who is a licensed *physician* or a *participating provider* who is a qualified licensed health care professional. A list of *web based care participating providers* may be obtained by calling Customer Service or by checking the PreferredOne website at www.preferredone.com.

You/Your

Refers to *covered employee, covered dependent or covered person*.

XX. Specific Information About *Your Plan*

The following information is furnished for the HSA medical option of the *Plan*:

Name of the *Plan*: This *Plan* shall be known as the Dunn County Employee Medical *Plan*. This restated *SPD* is effective January 1, 2013.

Address of the *Plan*: Dunn County
800 Wilson Avenue
Menomonie, WI 54751-2717

Type of *Plan*: Welfare Benefit Plan providing group health *benefits*

Group Number, as assigned by the *TPA*: PKA20225

Employer Identification Number: 39-6005690

***Plan Year/Plan Fiscal Year*:** January 1 through December 31

Third Party Administrator or *TPA*: The PreferredOne Administrative Services, Inc.
company that provides certain P.O. Box 59212
administrative services in connection with Menneapolis, MN 55459-0212
the *Plan*. *TPA* shall not be deemed an
employer with respect to the
administration of or provision of *benefits*
under *Plan Sponsor's Plan*.

***Plan Sponsor and Sponsor's Address*:** Dunn County
800 Wilson Avenue
Menomonie, WI 54751-2717

***Plan Administrator and Administrator's Address*:** *Plan Administrator* retains all
Dunn County
800 Wilson Avenue
Menomonie, WI 54751-2717
715.232.2429
fiduciary responsibilities with respect to
the *Plan*, except to the extent it has
delegated one or more such responsibilities
to others.

Named Fiduciary: *Plan Sponsor*
Dunn County

***Participating Provider*:** Open Access 200
HealthEOS

Agent for Service of Legal Process: Attention: Eugene C. Smith
Dunn County
800 Wilson Avenue
Menomonie, WI 54751-2717

Funding: This is a self-insured plan, not insured by the *TPA*; therefore the
Employer and the employee fund the plan to pay *claims*.