

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

**Amendment #2 to the
2012 Restated Summary Plan Description**

This Amendment is made a part of the Summary Plan Description (“SPD”), is effective January 1, 2013 except as otherwise stated herein, and is as follows:

1. The following new subsection entitled “Summary of Benefits and Coverage (SBC)” is hereby added at the end of Section IV. *Introduction to Your Coverage*, as follows:

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*.

2. *Preventive health care services* references in VI. P. *Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits* are deleted and replaced by the following:

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*.

3. The exclusions for “nutritional counseling” and “weight loss programs” in VI. M. *Hospital Services* and in VII. *Exclusions, 41. Hospital Services*, are deleted in their entirety and replaced with the following:
 - 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*.
 - 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*.
 - Nutritional and food supplements.
4. Any references to implantable and insertable (drug delivery) devices for birth control, and contraceptive devices and delivery methods other than implantable and insertable (drug delivery) devices, are hereby deleted in their entirety from VI. P. *Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits* and will be covered as *preventive health care services* in the “Preventive Contraceptive Methods and Counseling for Women” subsection of this amendment.

5. The exclusions for “health education”, “smoking cessation programs”, “nutritional counseling”, and “weight loss programs” in VI. P. Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits and in VII. Exclusions, 44. Office Visits and Urgent Care Center Visits and Designated Convenience Care Center Visits are deleted in their entirety and replaced with the following:
 - 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 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.
 - 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.
 - Nutritional and food supplements.
6. Any references to prescribed oral contraceptives, injectable contraceptives, contraceptive devices, and contraceptive delivery methods other than oral and injectable contraceptives, are hereby deleted in their entirety from VI. S. Prescription Drug Services and will be covered as preventive health care services in the “Preventive Contraceptive Methods and Counseling for Women” subsection of this amendment.
7. The list of exclusions in VI. S. Prescription Drug Services and in VII. Exclusions, 47. Prescription Drug Services is hereby amended by the addition of the following exclusion:
 - 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.
8. VI. T. Preventive Health Care Services is deleted in its entirety and replaced with the following subsections. (Note: the corresponding exclusions from both subsections below are also added to VII. Exclusions):

T.1 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, 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, mail order pharmacy, or received at a physician's office:

- Generic oral, injectable, implantable, and insertable contraceptives (received from a pharmacy or mail order pharmacy) that require a prescription under applicable law; and
- Brand name oral, injectable, implantable, and insertable contraceptives (received from a pharmacy or mail order pharmacy) that require a prescription under applicable law, and for which no generic alternative exists.

Pharmacy – up to a 30-day supply:

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

Mail order pharmacy - up to a 90-day supply:

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

Pharmacy – up to a 30-day supply:

Generic drugs: 100% of *eligible charges* after the *covered person* pays a \$10 *copayment* per prescription unit or refill.
Deductible does not apply.

Brand-name formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$20 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name non-formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$30 *copayment* per prescription unit or refill.
Deductible does not apply

Mail order: not applicable.

- Brand name oral, injectable, implantable, and insertable contraceptives (received from a pharmacy or mail order pharmacy) that require a prescription under applicable law, and for which a generic alternative exists.

Pharmacy – up to a 30-day supply:

Generic drugs: 100% of *eligible charges* after the *covered person* pays a \$10 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$20 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name non-formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$30 *copayment* per prescription unit or refill. *Deductible* does not apply.

Mail order pharmacy - 90-day supply:

Generic drugs: 100% of *eligible charges* after the *covered person* pays a \$10 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$20 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name non-formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$30 *copayment* per prescription unit or refill. *Deductible* does not apply.

Pharmacy – up to a 30-day supply:

Generic drugs: 100% of *eligible charges* after the *covered person* pays a \$10 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$20 *copayment* per prescription unit or refill. *Deductible* does not apply.

Brand-name non-formulary drugs: 100% of *eligible charges* after the *covered person* pays a \$30 *copayment* per prescription unit or refill. *Deductible* does not apply.

Mail order: not applicable.

<ul style="list-style-type: none"> Generic injectable, implantable, and insertable contraceptives (<u>received at a physician's office</u>) that require a prescription under applicable law; and Brand name injectable, implantable, and insertable contraceptives (<u>received at a physician's office</u>) that require a prescription under applicable law, and for which no generic alternative exists. 	<p>100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.</p>	<p>100% of <i>eligible charges</i> after a \$30 <i>copayment</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> per office visit; 100% of <i>eligible charges</i> after the <i>deductible</i>; thereafter.</p>
<ul style="list-style-type: none"> Brand name injectable, implantable, and insertable contraceptives (<u>received at a physician's office</u>) that require a prescription under applicable law, and for which a generic alternative exists. 	<p>100% of <i>eligible charges</i> after a \$30 <i>copayment</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> per office visit; 100% of <i>eligible charges</i> after the <i>deductible</i>; thereafter.</p>	<p>100% of <i>eligible charges</i> after a \$30 <i>copayment</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> per office visit; 100% of <i>eligible charges</i> after the <i>deductible</i>; thereafter.</p>
<ul style="list-style-type: none"> Sterilization procedures, excluding the reversal of sterilization procedures. 	<p>100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.</p>	<p>100% of <i>eligible charges</i> after a \$30 <i>copayment</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> per office visit; 100% of <i>eligible charges</i> after the <i>deductible</i>; thereafter.</p>
<ul style="list-style-type: none"> <i>Covered person</i> education and counseling about contraceptive methods. 	<p>100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.</p>	<p>100% of <i>eligible charges</i> after a \$30 <i>copayment</i> up to a maximum <i>Plan</i> payment of \$200 per <i>covered person</i> per office visit; 100% of <i>eligible charges</i> after the <i>deductible</i>; thereafter.</p>

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 *copayments* or *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 *copayments* 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 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.

T.2 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 Affordable Care Act, which includes such routine services as:

- Counseling for certain conditions.
- Immunizations, including flu shots when ordered by a physician or if not ordered by a physician, then provided by a participating provider.
- Laboratory tests, pathology and radiology.
- Physical examinations when ordered by a physician.
- Periodic prenatal exams.
- .
- 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.

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

• Routine eye examination	100% of eligible charges. Deductible does not apply.	100% of eligible charges. Deductible does not apply.
• Routine hearing examination	100% of eligible charges. Deductible does not apply.	100% of eligible charges. Deductible does not apply.
• Routine prenatal care exams and one routine postnatal exam.	100% of eligible charges. Deductible does not apply.	100% of eligible charges. Deductible does not apply.
• Child health supervision services*.	100% of 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 screenings from obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician* or prior approval from the *Plan*.

*Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations not already required to be covered under the ACA, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

9. The definition for *Preventive Health Care Services* in Section XVII. **Definitions of Terms Used** is deleted and replaced by the following:

Preventive Health Care Services The *covered services* that are listed and covered in this *SPD* as shown under the *Preventive Health Care Services* and/or Preventive Contraceptive Methods and Counseling for Women sections of the *Benefit Schedule*.

10. The following definition is added to Section XVII. **Definitions of Terms Used**:

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.

The following changes are effective January 1, 2014.

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

Routine Patient Costs Associated with Clinical Trials

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

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

Essential Health Benefits Benchmark

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

12. All references to “pre-existing condition exclusion” and/or “pre-existing condition limitation” contained in Section I. **Rights of Covered Persons**, subsection V. **B. Enrollment and Effective Date**, Section IX. **Leaves of Absence**, and Section XVII. **Definitions of Terms Used** are hereby deleted in their entirety.
13. Subsection V. **C. Pre-Existing Condition Limitation** is hereby deleted in its entirety.
14. Section V. is retitled “**Eligibility, Enrollment, and Effective Date**” and all references to this section in the provisions of the *SPD* are adjusted accordingly.
15. The Out-of-Pocket Limits provision contained in VI. **D. Out-of-Pocket Limit** is deleted in their entirety and replaced with the following:

D. Out-of-Pocket Limit	The <i>out-of-pocket limit</i> for services received from <i>participating providers</i> and <i>non-participating providers</i> is combined.	
	\$1,250 per <i>covered person</i> per <i>calendar year</i> ; \$2,800 per family (\$1,250 per <i>covered person</i>) per <i>calendar year</i> .	\$1,500 per <i>covered person</i> per <i>calendar year</i> ; \$3,400 per family (\$1,500 per <i>covered person</i>) per <i>calendar year</i> .

After you have met the *out-of-pocket limit* per *calendar year* for *copayments*, *coinsurance* and *deductibles*, the *Plan* covers 100% of all other *eligible charges incurred*. You pay any amount greater than the *out-of-pocket limit* if any *benefit maximum* or the *annual maximum* is exceeded. Expenses you pay for pre-certification penalties and 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.

16. The **Benefit Maximums** contained in VI. **E. Benefit Maximums** are deleted in their entirety and replaced with the following:

Benefit Maximums	
Annual <i>Benefit Maximum</i>	Unlimited.
Lifetime <i>Benefit Maximum</i>	Unlimited.

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

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

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

Coverage is limited to *rehabilitative therapy* or *habilitative therapy* that demonstrates measurable functional improvement within a reasonable period of time.

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

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

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

1. prescribed by a *physician* and provided by providers as defined in Wisconsin Administrative Code 3.36 (3) (f) through (m), and
2. approved by the Federal Food and Drug Administration, if the treatment is subject to the approval of the Federal Food and Drug Administration, and
3. medically and scientifically accepted evidence clearly demonstrates that the treatment meets all of the following criteria:
 - a. the treatment is proven safe.
 - b. the treatment can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the *covered person*.
 - c. the treatment meets the coverage terms of the *Plan* and is not specifically excluded under the terms of the *Plan*.

Intensive level services for:

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

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

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

Exclusions:

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

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

Mental health or substance related conditions that the *Plan Administrator* determines cannot be improved with treatment, except as stated in this *SPD*.

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

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

Investigative procedures and associated expenses.

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

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

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

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

21. Item 2. of subsection **XII. C. Order of Benefit Determination Rules** is deleted and replaced with the following:

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

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

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

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

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

22. XIV. B. Claims Appeal Process is deleted and replaced with the following:

B. Claim Appeals Process

Internal Appeals Process

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

1. Acute Care Services Appeals

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

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

2. Non-Acute Care Services Appeals

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

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

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

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

3. Concurrent Care Claims

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

4. Post-Service Appeals

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

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

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

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

5. Access to Relevant Documents

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

External Review Process

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

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

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

- a. Complete and eligible for external review; or

- b. Not complete, and will indicate what additional information or materials are needed to make it complete; or
- c. 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.

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

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

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

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

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

24. The following four definitions are added to Section XVII. **Definitions of Terms Used:**

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

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

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

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

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

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