WCA Group Health Trust
Marathon County
Medical Benefit Plan

Group Number: 76-440003
Revised: January 1, 2024

IMPORTANT MESSAGE

CHANGES IN ELIGIBILITY

You should report **ANY CHANGE IN ELIGIBILITY** to Your Employer within 30 days. Changes in eligibility include:

- Marriage, divorce or annulment
- Death of any Dependent
- Birth or adoption of a child
- Dependent child reaching the limiting age
- Disability
- Retirement
- Medicare eligibility

For specific details on maintaining coverage under the Plan, refer to SECTION 3 - ELIGIBILITY.

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SECTION 1 MEDICAL BENEFITS

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document.

PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan, subject to the deductibles, copayments, maximums and all other terms, provisions, limitations, conditions and exclusions of the Plan.

Reimbursement for covered services received from providers, including physicians or health care facilities, who are not part of Your network are determined based on one of the following:

1. Fee(s) that are negotiated with the physician or facility; or

2. The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services; or

3. Using current publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

PROVIDER NETWORK INFORMATION

This Plan has Preferred Provider Organization (PPO) and Non-Preferred Provider Organization (Non-PPO) benefits. A PPO provider is an In-Network provider. A Non-PPO provider is an Out-of-Network provider. Preferred Provider Organizations negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the Plan's incentives to use In-Network providers. These contracts establish a fair market value for health care services, which in most cases will reduce Your costs.

A provider may enter into an agreement to provide only certain covered health services or products, but not necessarily all covered health services or products. The participation status of providers may change from time to time, depending on whether they and the network wish to continue with the relationship and agree to terms.

It is the Covered Person's responsibility to verify network status each time they need services or products.

The WCA Group Health Trust has contracted one or more networks to provide services to this Plan in the areas that it has Employees. The Schedule of Benefits will define the network coverage offered by Your Plan. Each network consists of physicians, Hospitals and other medical care providers. The network that is applicable to You is shown on Your ID card. If Your Plan does not cover non-network benefits, services rendered are not payable for Out-of-Network providers, except as shown on the Schedule of Benefits.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Qualified Practitioners, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air ambulance transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Qualified Practitioners, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Coinsurance, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Qualified Practitioners who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Coinsurance, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Coinsurance, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air ambulance transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Coinsurance, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

1. For non-Emergency covered health care services received at certain network facilities from Out-of-Network Qualified Practitioners when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services, (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
   a. The reimbursement rate as determined by a state All Payer Model Agreement.
   b. The reimbursement rate as determined by state law.
   c. The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the Out-of-Network provider and the Claims Administrator.
   d. The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Qualified Practitioner may not bill You, for amounts in excess of Your applicable Copay, Coinsurance, or Deductible, based on the Recognized Amount as defined in this SPD.

1. For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
   a. The reimbursement rate as determined by a state All Payer Model Agreement.
   b. The reimbursement rate as determined by state law.
   c. The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the Out-of-Network provider and the Claims Administrator.
   d. The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Coinsurance, or Deductible, based on the Recognized Amount as defined in this SPD.

1. For air ambulance transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
   a. The reimbursement rate as determined by a state All Payer Model Agreement.
   b. The reimbursement rate as determined by state law.
   c. The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the Out-of-Network provider and the Claims Administrator.
   d. The amount determined by Independent Dispute Resolution (IDR).

Protection from Balance Billing – continued

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Coinsurance, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider's balance bill.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network. Retiree-only plans are not subject to the Continuity of Care requirements.

The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the network. In order to be eligible, You or Your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating network. You must also be one of the following:

1. An individual undergoing a course of treatment for a serious and complex condition that is either:
   a. An acute Sickness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
   b. A chronic Sickness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
2. An individual undergoing Inpatient or institutional care.
3. An individual scheduled for non-elective surgical care, including necessary postoperative care.
4. An individual who is pregnant and being treated.
5. An individual who is terminally ill and receiving treatment for such Sickness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

PRIOR AUTHORIZATION REQUIREMENTS

UMR, Inc. will handle the authorization requirements of Your Plan. You should call UMR CARE for authorization as soon as possible to receive proper care coordination. However, You must call within the time frames shown below. The toll-free number is shown on the back of Your ID card.

Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts UMR CARE as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. UMR CARE will then review the services provided.

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	REQUIREMENTS	TEXT PAGE
Inpatient Hospitalization • Inpatient maternity stays over 48 hours for normal delivery and 96 hours for a C-section. • Inpatient Behavioral Health (acute care) • Transplant and Transplant-related services • Skilled Nursing Facility • Residential Treatment	**In-Network**: No penalty (for the Covered Person). **Out-of-Network**: 25%, up to $250 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan. The penalty is not applied to the out-of-pocket maximum.	**In-Network**: **Your provider** is required to notify UMR for authorization. **Out-of-Network**: **You** must call UMR for authorization at least five days in advance of any Non-Emergency inpatient admission. If admission is on an emergency basis, UMR must be notified within 72 hours following Your admission, or as soon as medically possible.	1-18

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	REQUIREMENTS	TEXT PAGE
Durable Medical Equipment (excludes braces and orthotics): Over $1,000 in cost. Clinical Trials (Services related to the clinical trials) Dialysis Chemotherapy or Radiation (All Diagnoses) Infusion Therapy (Over $1,000 per infusion treatment) Genetic Testing Gender Dysphoria Treatment (Inpatient and outpatient services)	**In-Network**: No penalty (for the Covered Person). **Out-of-Network**: 25%, up to $250 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan. The penalty is not applied to the out-of-pocket maximum.	**In-Network and Out-of-Network**: **You** must call UMR for authorization.	1-18
Medical Specialty Medications Therapies: Physical, Occupational, Speech and Respiratory	No penalty (for the Covered Person).		

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF COVERAGE.

SCHEDULE OF BENEFITS

NOTE: UMR, Inc. is the Plan's Claims Administrator. UMR, Inc. provides clerical and claims processing services to the Plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the Plan, nor is UMR, Inc. a fiduciary to this Plan.

MEDICAL BILL REVIEW

You should carefully review Your bill for any service. If You find any errors such as:

1. Treatment that is billed, but was not received;

2. Incorrect arithmetic;

3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bill, with the errors circled, and the corrected bill to the address on Your ID card. This serves as proof that the provider of service agreed to the corrections. **If You are correct, You will receive 50% of the dollar amount of the errors in the bill, but not more than $500 paid per bill.**

MEDICAL BENEFITS

Plan Lifetime Maximum: Unlimited

SCHEDULE OF MEDICAL BENEFITS			
BENEFITS	***IN-NETWORK***	***OUT-OF-NETWORK***	***TEXT PAGE***
PROVIDER NETWORK	UHC Choice Plus		
CALENDAR YEAR	January 1 – December 31		
DEDUCTIBLE Single Employee + 1 Family ***Note:*** *$1,375 Single Limit for In-Network and Out-of-Network Employee +1 Coverage.*	 $2,000 $2,750 $3,500	 $2,000 $2,750 $3,500	1-17
COINSURANCE	90%	70%	1-17
OUT-OF-POCKET MAXIMUM *(Deductible, Coinsurance, Medical Copays and Prescription Drug Copays)* Single Employee + 1 Family ***Note:*** *$2,625 Single Limit for In-Network Employee +1 Coverage. $3,000 Single Limit for Out-of-Network Employee+1 Coverage.*	 $4,000 $5,250 $6,500	 $4,500 $6,000 $7,500	1-17
Note**:** *Deductible Does Not Apply to the Medicare Carve-Out Plans.* ***Note:*** *The In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are Combined.* ***Note:*** *Embedded - Deductible and Out-of-Pocket Family Maximums are on a Combined Dollar Basis. No One Covered Person in the Family May Incur More Than the Individual Maximum per Calendar Year.*			

PHYSICIAN SERVICES			
Office Visits – Primary Care	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	1-20
Specialist Office Visits	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	
Manipulations *(Limited to 12 Visits per Calendar Year. Routine and Maintenance Care is Covered)*	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	1-20

HOSPITAL SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Inpatient Hospital Services	Deductible/90%	Deductible/70%	1-20
Outpatient Hospital Services	Deductible/90%	Deductible/70%	1-24
Other Qualified Practitioner Benefits *(Inpatient and Outpatient Hospital Visits, Surgery and Anesthesia)*	Deductible/90%	Deductible/70%	1-20
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Office Visits	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	1-29
Outpatient Hospital Services	Deductible/90%	Deductible/70%	1-30
Inpatient Hospital Services	Deductible/90%	Deductible/70%	1-29
PREVENTIVE CARE SERVICES			
Routine Physical Exams *(Maximum of One Exam per Calendar Year) (Certain Services, Including all Lab Tests, Whether Routine or with a Diagnosis, Billed with a Routine Physical Exam may be Payable the Same as the Preventive Care Services Benefit. Office Surgeries are Excluded. Limited to 30 Days prior to or after Routine Physical Exam is Performed.)*	100%, Deductible Waived	$50 Copay per Visit, then Deductible/70%	1-22
Routine Lab Tests	100%, Deductible Waived	Deductible/70%	
Immunizations *(Routine Immunizations)*	100%, Deductible Waived		1-22
Preventive Care Exams *(Routine & Non-Routine Exams)*			
Colorectal Screenings *(e.g., Colonoscopy, Sigmoidoscopy)*	100%, Deductible Waived *(1st Exam of Calendar Year)*	Deductible/70% *(1st Exam of Calendar Year)*	1-37
	Deductible/90% *(Additional Exams in Calendar Year)*	Deductible/70% *(Additional Exams in Calendar Year)*	
Fecal DNA Testing *(e.g., Cologuard)*	100%, Deductible Waived *(1st Exam of Calendar Year)* In-Network Deductible/90% *(Additional Exams in Calendar Year)*		

Preventive Care Exams *(Routine & Non-Routine Exams)*	***IN-NETWORK***	***OUT-OF-NETWORK***	***TEXT PAGE***
Mammograms *(Includes 3D Mammograms)*	100%, Deductible Waived *(1st Exam of Calendar Year)*	Deductible/70% *(1st Exam of Calendar Year)*	1-36
Pap/Pelvic Exams	Deductible/90% *(Additional Exams in Calendar Year)*	Deductible/70% *(Additional Exams in Calendar Year)*	1-37
Prostate Exams/PSA Tests			1-37
Vision Exams	100%, Deductible Waived *(1st Exam of Calendar Year)* In-Network Deductible/90% *(Additional Exams in Calendar Year)*		1-36
EMERGENCY/URGENT CARE SERVICES			
Ambulance Services *(Limited to Appropriate Air or Ground Transport to the Nearest Facility Equipped to Treat the Sickness or Injury.)*	In-Network Deductible/90%		1-25
Emergency Room Services *(Copay Waived if Admitted to Hospital from Emergency Room within 24 Hours)*	$200 Copay per Visit, then In-Network Deductible/90%		1-24
Urgent Care Services	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	1-24
FastCare Clinic	100%, Deductible Waived		
X-RAY & LABORATORY SERVICES			
Diagnostic Lab/X-Ray Services ***(Non-Routine)*** *(Limited to 4 Urinary Drug Screenings per Calendar Year; Emergency or Urgent Care Visits Not Included in Limit. Non-Medical Screenings Not Covered.)*	Deductible/90%	Deductible/70%	1-24
High Tech Imaging ***(MRI/MRA/CT/PET Scans)***	Deductible/90%	Deductible/70%	
REHABILITATION THERAPY			
Outpatient Cardiac Rehabilitation Services *(Phase II Only. Phase III is Not Covered.)*	Deductible/90%	Deductible/70%	1-34
Physical, Speech, Occupational & Respiratory Therapy	$25 Copay per Visit, then Deductible/90%	$50 Copay per Visit, then Deductible/70%	1-34

OTHER COVERED SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Allergy Testing/Treatment	Deductible/90%	Deductible/70%	1-35
Ambulatory Surgical Center	Deductible/90%	Deductible/70%	1-24
Birthing Center Services	Deductible/90%	Deductible/70%	1-26
Blood Services *(Includes blood and blood plasma that is not replaced by donation and blood products or extracts and their administration in excess of the first three pints each Calendar Year)*	Deductible/80%	Deductible/70%	1-34
Breast Pumps *(Maximum of $400 per Pregnancy, Including Certain Supplies, Taxes and Shipping)*	100%, Deductible Waived		1-22
Durable Medical Equipment	Deductible/80%	Deductible/70%	1-34
Gender Dysphoria	Deductible/90%	Deductible/70%	1-39
Travel And Lodging *(Limited to $2,000 per Calendar Year)*	Deductible/90%	Not Covered	
Home Health Care Services *(Limited to 50 Visits per Calendar Year)*	Deductible/90%	Deductible/70%	1-26
Hospice Care Services *(Bereavement Counseling Limited to 15 Visits per Family, per Calendar Year)*	Deductible/90%	Deductible/70%	1-27
Maternity Services	Deductible/90%	Deductible/70%	1-25
Morbid Obesity *(Limited to One Procedure per Lifetime)*			1-41
Surgical Treatment	$2,500 Copay per Procedure, then Deductible/90%	$2,500 Copay per Procedure, then Deductible/70%	
Other Covered Expenses	Deductible/90%	Deductible/70%	
Nicotine Addiction			1-36
Office Visits *(Subject to Provider Office Copay)*	Deductible/90%	Deductible/70%	
Other Covered Expenses	100%, Deductible Waived		
Oral Surgery	Deductible/90%	Deductible/70%	1-21
Dental Injury and Extraction of Seven or More Teeth	Deductible/80%	Deductible/70%	

OTHER COVERED SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Pre-Admission Testing Services	Deductible/90%	Deductible/70%	1-36
Prosthetic Appliances *(Limited to One of Each Type of Appliance Every Five Calendar Years)*	Deductible/80%	Deductible/70%	1-35
Second Surgical Opinion	Deductible/90%	Deductible/70%	1-36
Skilled Nursing Facility Services *(Limited to 60 Days per Confinement)*	Deductible/90%	Deductible/70%	1-26
Special Medical Supplies	Deductible/80%	Deductible/70%	1-35
Teladoc *(Medical, Behavioral Health and Dermatology Coverage)*	100%, Deductible Waived		1-31
Telehealth **Office Visits** **Outpatient**	 $25 Copay per Visit, then Deductible/90% Deductible/90%	 $50 Copay per Visit, then Deductible/70% Deductible/70%	1-39
Vision Hardware *(Limited to Either Eyeglasses or Contact Lenses per Calendar Year; Coverage Includes Only Items Listed Below.)* *(Eyeglass Lenses: Limited to 1 Pair Single Vision, Bifocal, No-Line Bifocal or Trifocal Lenses, Including Progressive, per Calendar Year)* **Pediatric Services** ***(Up to 19 Years of Age)*** *(Frames: Limited to 1 Set Every 12 Months; Lenses: Limited to 1 Set Every 12 Months) Contact Lenses: Limited to 1 Set Every 12 Months or a 12-Month Supply of Disposables)* **Non-Pediatric Services** ***(Ages 19 and Older)*** *(Frames: Limited to 1 Set Every 12 Months; Lenses: Limited to 1 Set Every 12 Months) Contact Lenses: Limited to 1 Set Every 12 Months. Limited to $100 for Frames and Contact Lenses per Calendar Year or a 12-Month Supply of Disposables)*	100%, Deductible Waived	100%, Deductible Waived	1-36
	Center of Excellence	***Non-Center of Excellence***	
Transplants	Deductible/90%	Deductible/70%	1-28

STATE MANDATED BENEFITS	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Blood Lead Tests ***(Not Covered Under Preventive Care Services)*** *(Covered Dependent Children under Age 6)*	Deductible/90%	Deductible/70%	1-42
Hearing Hardware ***(Covered Persons under Age 18)*** *(Maximum of 1 Hearing Aid per Ear every 3 Calendar Years; Cochlear Implants and Bone-Anchored Hearing Aids)*	Deductible/90%	Deductible/70%	1-43
Dental Services ***(Hospital or Ambulatory Surgical Services)*** *(Refer to the State Mandated Benefits Section for Details Regarding this Benefit)*	Deductible/90%	Deductible/70%	1-42
TMJ Treatment	Deductible/80%	Deductible/70%	1-42
Other State Mandated Benefits	Deductible/90%	Deductible/70%	1-42

PRESCRIPTION DRUG CARD				*TEXT PAGE*
Drug Tier	**Retail 30 Day Supply**	**Retail 31-90 Day Supply**	**Mail Order 90 Day Supply**	1-52
Value Priced Generic	$0	$0	$0	
Generic	$5	$15	$5	
Preferred	$20	$60	$40	
Non-Preferred	$40	$120	$80	
Specialty	Subject to Applicable Tier Copay Maximum 30 Day Supply, Mail Order Only			
Other Prescription Drug Card Provisions	**Certain Diabetic Supplies:** Insulin: $5 Copay Test strips, lancets and needles: $0 Copay, Deductible Waived **Preventive Drugs**: Copays may be waived for certain preventive prescription, over-the-counter products and prescription contraceptives. **Specialty Pharmacy Program**: Certain injectable (Specialty) drugs are required to be purchased through the Drug Card's Specialty Pharmacy Program. (Refer to the text for more details.) **Specialty Drugs**: Administration of these injectable (Specialty) drugs in a physician's office or other outpatient facility is limited to one office or outpatient visit and two home care visits for drug administration training per prescription. After the limit is met, the Specialty drugs must be purchased through the Specialty Pharmacy Program. **Note:** Coverage includes all Covered Persons who are eligible for prescription drug coverage.			
Prescription Drug Out-of-Pocket Maximum	Included in the Medical Out-of-Pocket Maximum			

LIMITATIONS & EXCLUSIONS – SEE TEXT FOR DETAILS

NETWORK BENEFIT PROVISIONS

In addition to services required to be covered as specified under the Protection from Balance Billing section, the following benefits may be processed at the In-Network benefit level when provided by an Out-of-Network provider if applicable:

1. In-Network benefits will be payable for Out-of-Network provider services **only** if You receive treatment that is a Covered Expense from an In-Network provider and as a result of that treatment, a Covered Expense is incurred for pathology, radiology, or anesthesiology services from an Out-of-Network provider;

2. You are currently under a care plan with an Out-of-Network provider and the care is eligible under the Transition of Care or Continuity of Care provision of this Plan, if applicable;

3. Covered Expenses provided by a Qualified Practitioner during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital;

4. Covered Expenses provided by an Emergency room Qualified Practitioner will be payable at the In-Network level of benefits when provided at an In-Network Hospital;

5. If there is no In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50-mile radius of the Covered Person's residence, the Covered Person may be eligible to receive In-Network benefits from the Out-of-Network provider for covered services. In this situation, You or Your provider must notify and receive a Network Exception Approval letter from the Claims Administrator prior to any services or supplies being received. The Claims Administrator will work with You and Your provider to coordinate care through an Out-of-Network provider.

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered Expenses are payable, after satisfaction of the deductible at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

Deductible

The deductible applies to each Covered Person, each Calendar Year. Only charges which qualify as a Covered Expense may be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

Employee +1 Deductible

The deductible applies to each Covered Person, each Calendar Year. Only charges that are a Covered Expense will be used to satisfy the deductible. The deductible amounts for each person are shown on the Schedule of Benefits.

Maximum Family Deductible

The total deductible applied to all Covered Persons in one family, in a Calendar Year, is subject to the maximum shown on the Schedule of Benefits. Once Your family reaches this maximum for a Calendar Year, no further deductibles will be applied during that Calendar Year.

Coinsurance

Benefits are payable at the percentage rate shown on the Schedule of Benefits, after the deductible is satisfied each Calendar Year. Benefits are payable for the rest of the Calendar Year or up to any Plan maximums at the percentage rate shown on the Schedule of Benefits.

Copayments or Copays

The copay for a Covered Expense will apply each time that expense is received. The amount of the copay varies by the type of service provided. All copays are shown on the Schedule of Benefits.

Out-of-Pocket Maximum

The out-of-pocket maximum is shown on the Schedule of Benefits. The out-of-pocket maximum is made up of the deductible, coinsurance and copays, if applicable. When the out-of-pocket maximum has been met for a Covered Person or family, the Plan will pay 100% of Covered Expenses for the rest of the Calendar Year. Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays will not be used to meet the out-of-pocket maximums. Penalties as a result of failure to comply with Prior Authorization requirements do not apply to the out-of-pocket maximums.

PRIOR AUTHORIZATION REQUIREMENTS

HOW THE PROGRAM WORKS

When You call UMR, Inc. for authorization, You will be asked the following questions:

1. Group name and number
2. Name of Employee
3. Employee's participant number
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once Prior Authorization is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new Prior Authorization must be made if: You do not receive the treatment within 30 days of the scheduled date; You use a different facility or physician; or You are admitted for a different reason.

PRIOR AUTHORIZATION REQUIREMENTS

You or Your Qualified Practitioner are required to notify UMR CARE for authorization prior to receiving certain types of health care. The services that require Prior Authorization are listed in the section prior to the Schedule of Benefits. **If You are required to provide Prior Authorization and fail to do so, benefits may be reduced or denied.**

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY

If You are required to obtain Prior Authorization and it is not provided, Your treatment will be reviewed when a claim is received. If it is determined to be a Covered Expense, benefits that are otherwise payable will be reduced as shown under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket maximum.

If Your treatment is not a Covered Expense, no benefits will be payable under the Plan.

MEDICAL SPECIALTY DRUG PROGRAM

To encourage safe and cost-effective medication use, prior authorization is required for some specialty drugs. Please visit https://fhs.umr.com/print/UM1428.pdf for a list of Medical Specialty Drugs that requires prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage.

NOTICE OF SECONDARY COVERAGE WAIVER

If this Plan is secondary to another medical plan that also covers You, Prior Authorization will not be required.

CASE MANAGEMENT

Case management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. Participants are identified by using system-integrated, automated and manual trigger lists, including the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer referrals or self-referrals. UMR CARE works directly with the patient, the patient's family members, the treating physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future.

MATERNITY CARE

Maternity CARE provides pre-pregnancy education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted by CARE nurses at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. UMR's pre-pregnancy support program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the Maternity CARE program by calling our toll-free number or enrolling online at www.umr.com. They are then contacted by CARE nurses who have extensive clinical backgrounds in obstetrics/gynecology.

A Covered Person who enrolls during the first or second trimester and actively participates in the Maternity CARE program will receive a prepaid $25 reward card.

REAL APPEAL PROGRAM

This Plan provides the Real Appeal Program, which represents a practical solution for weight-related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18 who meet certain requirements as defined by Real Appeal. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live, virtual coach. The experience will be personalized for each individual though an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share to the Covered Person. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal Program. If Covered Persons would like to participate, or would like any additional information regarding the program, they can visit the Real Appeal website at Rally Coach – Login (werally.com).

MEDICAL COVERED EXPENSES

CHIROPRACTIC SERVICES

Manipulations and other services billed by a chiropractor or any other Qualified Practitioner for the treatment of a Sickness or Injury. The following services and supplies are not covered under this benefit: a) massage therapy services, b) supplies or counseling in connection with any supplies such as vitamins, herbs, nutritional supplements, cervical pillows, heel lifts and lumbar rolls, or c) orthotic devices, unless custom made and prescribed by a Qualified Practitioner.

INPATIENT HOSPITAL BENEFIT

Charges made for the following services or supplies furnished by a Hospital are payable as shown on the Schedule of Benefits, subject to the Protection from Balance Billing allowed amount as applicable.

Room and Board

Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the Hospital, unless necessary due to Your Sickness or Injury or the Hospital offers only private rooms for the services provided, such as birthing rooms.

Hospital Miscellaneous Charges

Charges made by the Hospital on its own behalf for services and supplies furnished for Your treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests; and

2. Professional services of an anesthesiologist.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 24 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

QUALIFIED PRACTITIONER BENEFIT

Benefits are payable as shown on the Schedule of Benefits and include charges made by a Qualified Practitioner for the following services:

1. Qualified Practitioner office visits;

2. Inpatient Hospital visits by a Qualified Practitioner;

3. Outpatient medical services by a Qualified Practitioner;

4. Surgical services. A surgical procedure, including pre- and post-operative care and subsequent care for surgeries performed in the outpatient department of a Hospital or Ambulatory Surgical Center. Diagnostic x-ray and laboratory services related to a covered surgery are also a Covered Expense under this benefit.

   Subsequent surgical procedures (i.e. suture or cast removal) will only be considered for payment as a separate service when performed by a Qualified Practitioner other than the operating surgeon.

Qualified Practitioner Benefit – continued

5. Assistant surgeon services. The services of a second surgeon or a licensed surgical assistant are a Covered Expense only when the services are necessary for the safe and effective performance of a covered surgical procedure;

6. Administration of anesthesia. Payable only if not included in the global surgical fee;

7. Services provided by an anesthesiologist or anesthetist to monitor the Covered Person's vital signs; and

8. Services performed in a Convenient Care clinic.

ORAL SURGERY BENEFIT

Charges made for the following oral surgical procedures are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. Hospital or Ambulatory Surgical Center services are also covered.

1. Surgical procedures required to correct Accidental Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

2. Apicoectomy (the excision of the apex of the tooth root);

3. Root canal therapy (if performed in conjunction with an apicoectomy);

4. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

5. Excision of benign bony growths of the jaw and hard palate;

6. External incision and drainage of cellulitis;

7. Incision of sensory sinuses, salivary glands or ducts;

8. Excision of partially or completely unerupted impacted teeth;

9. Reduction of dislocations of, and excision of, the temporomandibular joints (**TMJ**);

10. Frenectomy (the cutting of the tissue in the midline of the tongue);

11. Excision of exostosis (bony outgrowth) of the jaws and hard palate;

12. Gingivectomy (the excision of gum tissue to eliminate infection);

13. Alveolectomy, if performed for reasons other than preparation for dentures;

14. Functional osteotomies;

15. Hospital services, if Confinement is Medically Necessary;

16. Extraction of seven or more natural teeth in one operative session;

Oral Surgery Benefit – continued

17. Setting of fractures of the jaw and repair of or initial replacement of natural teeth damaged due to Injury. To be a Covered Expense under the Plan, the treatment must be incurred within 90 days of the Injury. Damage resulting from biting or chewing will not be considered an Injury; and

18. Dental exams performed in preparation for a covered oral surgery.

PREVENTIVE CARE SERVICES BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Covered Expenses include but are not limited to the following:

1. Preventive medicine visits (wellness exams, including well child care);
2. All standard immunizations recommended by the American Committee on Immunization Practices. Immunizations for foreign travel are also covered under this benefit.

Screening For Services at Appropriate Ages

(**Note**: Colonoscopies are payable under a separate benefit, as shown on the Schedule of Benefits.)
1. Elevated cholesterol and lipids;
2. Certain sexually transmitted diseases and HIV;
3. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
4. High blood pressure;
5. Diabetes;
6. Depression;
7. Screening for counseling for obesity (adults and children);
8. Cardiac calcium scans; and
9. Bone density tests.

For Women

(**Note**: Pap smears, pelvic exams and mammograms are payable under a separate benefit, as shown on the Schedule of Benefits.)
1. Genetic testing and counseling for BRCA breast cancer gene;
2. Screening for gonorrhea, chlamydia, syphilis;
3. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
4. Instructions to promote and help with breast feeding;
5. Screening for osteoporosis;
6. Counseling for those at high risk for breast cancer for chemoprevention;
7. Gynecological exams;
8. Routine pre-natal care;
9. Routine gestational diabetes screening;
10. Human papillomavirus (HPV) DNA testing;
11. Counseling for sexually transmitted infections (provided annually);
12. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
13. Breastfeeding support, supplies and counseling in conjunction with each birth. Benefits include comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and charges for the rental or purchase of breastfeeding equipment. Retail and over-the-counter equipment, certain supplies, sales tax and shipping charges are payable under the Preventive Care Services benefit at the In-Network level of benefits. (A prescription is not required). Maximum of one breast pump per pregnancy. <u>The below criteria is applied to the purchase of breast pumps</u>:

Preventive Care Services Benefit - continued

a. **Hospital Grade Breast Pump**: Rental Only:
Hospital Grade Breast Pumps (heavy duty designed for multiple users), and the personal use attachment kit, are covered for a Covered Person who is a lactating mother when the Covered Person obtains the hospital grade breast pump within the first two months (60 days) following delivery and their infant has met one or more of the following criteria:

i. Hospitalized newborn infant; or
ii. Congenital malformations or genetic abnormalities impacting feeding (e.g. cleft lip and palate, Down syndrome).

b. **Personal Use Double Electric Breast Pump**:
High quality, personal use double electrical breast pumps have been shown to be as effective as Hospital grade pumps in outpatient settings, including for mothers with maternal infant separation for work or school and no other identified lactation risk factors.

A personal use double electrical pump may be covered for the Covered Person with the following criteria:

i. The woman is a lactating mother; and
ii. The Covered Person should obtain the breast pump within one year (365 days) of delivery.

14. Screening and counseling for interpersonal and domestic violence (provided annually); and
15. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), such as insertable vaginal devices, injections and administration, devices (e.g. IUD, implants) including insertion and removal, sterilizations, patient education and related office services. (Note: Birth control pills, patches and self-insertable devices may be covered under the Drug Card. Birth control injections, implants and other devices that are not covered under the Drug Card will be covered under the medical Plan.)

For Men

(**Note**: PSA tests are payable under a separate benefit, as shown on the Schedule of Benefits.)
1. Screening for abdominal aortic aneurysm;
2. Human papillomavirus (HPV) DNA testing;
3. Counseling for sexually transmitted infections (provided annually);
4. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
5. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), including patient education and related office services. Sterilization is covered under Preventive Care Services unless this Plan is a Qualified High Deductible Health Plan; in that case, sterilization is covered as any other Sickness or Injury; and
6. Screening and counseling for interpersonal and domestic violence (provided annually).

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for Developmental Delay/autism;
5. Screening for lead and tuberculosis. (Note: Blood lead tests that are not covered under this benefit are payable as shown under the State Mandated Benefits section of this Plan);
6. Preventive/routine oral fluoride supplements prescribed for Dependent children ages six months to five years old whose primary water source is deficient in fluoride; and
7. Third party exams for Dependent children (as such children are defined in this Plan.) Limited to routine exams required for school, sports and camps only. Maximum of one third-party exam per Calendar Year.

Preventive Care Services Benefit - continued

Please visit the following links for additional information:

https://www.healthcare.gov/preventive-care-benefits/
https://www.healthcare.gov/preventive-care-children/
https://www.healthcare.gov/preventive-care-women/

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient Hospital services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of Your Sickness or Injury;

2. Diagnostic x-rays and laboratory services;

3. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by Your attending Qualified Practitioner; and

4. Emergency room charges, but **only** if incurred due to:

    a. Emergency Accident treatment,
    b. a surgical procedure, or
    c. treatment of a Sickness that is a medical Emergency.

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 24 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

URGENT CARE CENTER BENEFIT

Charges for Covered Expenses provided by an Urgent Care Center are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by a free-standing surgical facility or Ambulatory Surgical Center, on its own behalf, for surgical procedures performed and for Hospital miscellaneous services provided in the facility.

X-RAY AND LABORATORY SERVICES

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A Qualified Practitioner must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered Injury or oral surgery. Cardiac calcium scans are payable as any other Sickness or Injury. (Routine cardiac calcium scans are payable under the Preventive Care Services benefit.)

EMERGENCY CARE BENEFIT

Health care services and supplies necessary for the treatment of an Emergency.

AMBULANCE SERVICE BENEFIT

Charges for licensed ground ambulance service to the nearest facility that is equipped to treat Your Sickness or Injury. Licensed air ambulance to the nearest facility equipped to treat Your Sickness or Injury, but only if such air transport is required for the treatment of Your Sickness or Injury. Licensed ambulance transport between medical facilities, but only if You cannot be treated safely and effectively in the facility where You are confined and Your Sickness or Injury requires the attendance of medical professionals during Your transport. In this case, benefits are limited to the cost of transportation to the nearest facility equipped to treat Your Sickness or Injury. If You need care that is not available in a local Hospital, transport to the nearest Hospital that can provide the care is covered. If You require care that is not available by ground ambulance, air ambulance service to the nearest Hospital that can provide the care is covered. Refer to the Protection from Balance Billing section for the No Surprises Act requirements specific to air ambulance.

Ambulance transport that is primarily for the convenience of the patient, a family member or the Qualified Practitioner is not a Covered Expense.

MATERNITY BENEFIT

Pregnancy is a Covered Expense for any Covered Person and payable as shown on the Schedule of Benefits. Complications of Pregnancy are payable as any other covered Sickness at the point the complication sets in.

Hospital and Qualified Practitioner services in performing therapeutic abortions are Covered Expenses. Complications of abortions are payable for any Covered Person at the point the complication sets in.

Nurse-midwife services related to prenatal care, labor and delivery and postpartum care performed by either: 1) a registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Midwives and the State of Wisconsin; or 2) a licensed nurse certified as a nurse-midwife in the state in which he or she practices. Except for Emergencies, You must receive the nurse-midwife services in a health care facility approved for the practice of nurse-midwifery by the state in which it is located.

Childbirth education classes (e.g. Lamaze) are not covered under this Plan.

Amniocentesis, chorionic villi sampling or ultrasounds performed to alleviate anxiety or to determine the gender of the fetus are not covered under this Plan.

Under federal law, group health plans and health insurance issuers offering group health plan 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 plan or 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, plans and 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 plan or 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 Prior Authorization. For information on Prior Authorization, contact Your Plan Administrator.

NEWBORN BENEFIT

This benefit does **not** apply unless You enroll Your newborn Dependent within 60 days of the date of birth. See the "Eligibility" section of this booklet for more information.

A newborn child of a Covered Employee is covered during the first 60 days of life. Dependent coverage **must** be in force for coverage to continue past the first 60 days of life. If Dependent coverage is not in force at the end of the 60 days, the child's coverage will terminate immediately.

However, coverage may still be effective on the child's date of birth if the following conditions are met: Coverage is applied for within 12 months of the child's date of birth and all back contributions due are paid.

Newborn Coverage

Covered Expenses incurred during the period of the mother's hospitalization following delivery. Hospital charges for nursery room, board and care; the Qualified Practitioner's charge for circumcision of a male newborn child; and the Qualified Practitioner's charges for routine examination of the newborn child before release from the Hospital.

Covered Expenses also include expenses incurred for the following: Sickness or Injury; necessary care and treatment for premature birth; medically diagnosed birth defects and abnormalities; and surgery to repair or restore any body part necessary to achieve normal body functioning. Covered Expenses do **not** include Expenses Incurred for plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to Injury, infection or other disease of the involved part; or

2. Congenital disease or anomaly of a covered Dependent child which resulted in a functional defect.

BIRTHING CENTER BENEFIT

Services and supplies provided in a Birthing Center for prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

SKILLED NURSING FACILITY BENEFIT

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

HOME HEALTH CARE BENEFIT

Home Health Care services are provided when such services are determined to be Medically Necessary.

Covered Expenses may include:

1. Home visits instead of visits to the Qualified Practitioner's office that do not exceed the maximum allowable under this Plan;
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period;
3. Nutrition counseling provided by or under the supervision of a qualified dietician or other Qualified Practitioner, if applicable;

Home Health Care – continued

4. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a qualified therapist or other Qualified Practitioner, if applicable; and
5. Medical supplies, drugs, or medication prescribed by a Qualified Practitioner and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a qualified therapist, qualified dietician or other Qualified Practitioner, if applicable.

Exclusions

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following services or supplies:

1. Homemaker or housekeeping services;
2. Supportive environment materials such as handrails, ramps, air conditioners and telephones;
3. Services performed by family members or volunteer workers;
4. "Meals on Wheels" or similar food service;
5. Separate charges for records, reports or transportation;
6. Expenses for the normal necessities of living such as food, clothing and household supplies; or
7. Legal and financial counseling services, unless otherwise covered under this Plan.

HOSPICE CARE BENEFIT

1. Room and board and related services and supplies;

2. Part-time nursing care by or supervised by a registered nurse (RN);

3. Counseling by a licensed clinical social worker. Counseling by a pastoral counselor. Benefits are provided for the hospice patient and immediate family;

4. Bereavement counseling by a licensed clinical social worker. Bereavement counseling by a pastoral counselor. Benefits are limited to 15 visits per family;

5. Medical social services for You and Your Immediate Family under the direction of a Qualified Practitioner, including:

    a. assessment of social, emotional and medical needs, and the home and family situation,
    b. identification of the community resources available and assisting in obtaining those resources;

6. Dietary counseling;

7. Consultation and case management services by a Qualified Practitioner;

8. Physical or occupational therapy;

9. Home Health Care and related supplies;

10. Part-time home health aide service, up to eight hours per day; and

11. Medical supplies, drugs and medicines prescribed by a Qualified Practitioner.

Hospice Care Benefit – continued

Hospice care must be furnished in a Hospice Facility or by a Hospice Care Agency in Your home. Hospice Care must be instead of a covered Confinement in a Hospital or Skilled Nursing Facility. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less.

Limitations

Hospice care benefits do **not** include private or special nursing services, a Confinement not required for pain control or other acute chronic symptom management, funeral arrangements or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services, sitter or companion services, house cleaning or household maintenance, services by volunteers or persons who do not regularly charge for their services, services by a licensed pastoral counselor to a member of his congregation or respite care.

TRANSPLANTS

The following human organ or tissue transplants are payable as shown on the Schedule of Benefits when the transplant is provided from a human donor to a living human transplant recipient and the attending Qualified Practitioner certifies that the transplant is Medically Necessary. Benefits are subject to the Protection from Balance Billing allowed amount.

1. Bone marrow transplant, stem cell transplant (allogeneic and autologous) and cellular therapy chimeric antigen receptor T-cell Therapy (CAR-T) for certain conditions, when not experimental or investigational. The Covered Person must request in advance, from the Plan, a determination as to whether it is covered or excluded as experimental or investigational;

2. Cornea transplants;

3. Arteries or veins;

4. Heart transplants;

5. Heart lung transplants (combined procedures);

6. Kidney transplants;

7. Liver transplants;

8. Lung transplants;

9. Pancreas transplants;

10. Kidney pancreas transplants (combined procedures);

11. Small bowel transplants; and

12. Any other tissue or organ transplant that may be covered elsewhere in this Plan.

NOTE: THE PLAN SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS YOU ARE AWARE OF THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR YOU.

Transplants - continued

Living donors: Such donors are covered only if the recipient is also a Covered Person under this Plan.

When both the recipient and donor are covered by this Plan, each is entitled to benefits under the Plan.

When only the recipient is covered by the Plan, both the donor and the recipient are entitled to the benefits of the Plan. The donor's benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the Plan.

When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient.

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

The Plan does not cover animal to human transplants or artificial or mechanical devices designed to replace human organs.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

NOTE: Inpatient Hospital admissions for the treatment of psychological disorders, chemical dependence and alcoholism require Prior Authorization, as shown in the Prior Authorization section of the Schedule of Benefits (under the section about Inpatient Hospital Admissions).

The following expenses incurred by You during a plan of treatment for a psychological disorder, chemical dependence or alcoholism are payable as shown on the Schedule of Benefits. Benefits are subject to the Protection from Balance Billing allowed amount as applicable.

1. Charges made by a Qualified Practitioner;

2. Charges made by a Hospital;

3. Charges made by a Qualified Treatment Facility; and

4. Charges for nutritional counseling when it is part of an approved treatment plan prescribed by a Qualified Practitioner, provided by a certified or registered dietician and necessary for the effective treatment of a life-threatening Sickness (e.g. anorexia nervosa).

Inpatient Benefits

Covered Expenses while confined as a patient in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits.

Transitional Treatment Benefits

Covered Expenses for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs: adult day treatment programs, child and adolescent day treatment programs and services provided by a residential treatment program. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, half-way houses, and group homes).

Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Covered Expenses for outpatient treatment received while not Confined in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits.

Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

HEARING SERVICES

Hearing Aid Discount Program

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:
a. Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
b. Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
c. Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:
a. Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).

b. Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
c. If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

TELADOC SERVICES

Medical

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with physicians for routine primary medical diagnoses. This benefit does not apply to Covered Persons who have Medicare coverage.

Teladoc may be used:

1. When immediate care is needed.
2. When considering the ER or urgent care center for non-Emergency issues.
3. When You are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

1. General medicine, including, but not limited to:
   a. Colds and flu
   b. Allergies
   c. Bronchitis
   d. Pink eye
   e. Upper respiratory infections
2. A refill of a recurring Prescription.
3. Pediatric care.
4. Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a physician. A physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc does not guarantee that every consultation will result in a prescription. Medications are prescribed at the doctor's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc with any clarification questions. A member of the Teladoc clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another physician consultation for the same condition within 72 hours after the consultation call, he or she will be charged the Teladoc consultation fee.

Teladoc may not be used for:

1. Drug Enforcement Agency (DEA) controlled Prescriptions.
2. Charges for telephone or online consultations with physicians and/or other providers who are not contracted through Teladoc.

Teladoc Services - continued

Behavioral Health Program

The Behavioral Health Program includes access to behavioral health Providers who provide behavioral health consultations to Covered Persons by telephone or video conference. The Behavioral Health Program offers Covered Persons ongoing access to behavioral diagnostic services, talk therapy, and prescription medication management, when appropriate. The behavioral health Providers are selected and engaged to provide behavioral health clinical intake assessments in accordance with behavioral health protocols and guidelines that are tailored to the telehealth industry.

Behavioral Health Consultations: In order for a Covered Person to receive a behavioral health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Behavioral Health Program. This disclosure may be completed either online or by telephone with a designated Behavioral Health Program representative. In addition, the Covered Person must also agree to Teladoc's Informed Patient Consent and Release Form confirming an understanding that the behavioral health Provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the behavioral health providers through the Behavioral Health Program.

Scheduling: Teladoc will provide the Covered Person with information identifying each behavioral health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each behavioral health provider to allow the Covered Person to choose the provider from whom he or she wishes to receive treatment. The Covered Person may schedule consultations through either Teladoc's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different behavioral health provider. There are no limitations on the number of behavioral health consultations a Covered Person may receive under the Behavioral Health Program.

Individual Sessions: The initial behavioral health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the behavioral health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A behavioral health provider may determine that the treatment of a Covered Person's particular behavioral health issue would be managed more appropriately through in-person therapy. In such a case, the behavioral health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the general medicine program, the behavioral health consultations under the Behavioral Health Program:

1. Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a behavioral health consultation with a behavioral health provider and the consultation must occur within a time period for which the behavioral health provider is scheduled to support the Behavioral Health Program.
2. Are not intended to be cross-coverage consultations. Rather, the Behavioral Health Program is designed to make behavioral health providers available by telephone or video conference even when another behavioral health counselor is available to the Covered Person for an in-person visit.
3. Are not intended to be provided in Emergency situations.
4. Are not available for Teladoc therapy for Covered Persons under the age of 13.
5. Are not available for Teladoc psychiatry for Covered Persons under the age of 18.

Teladoc Services - continued

Dermatology Services Program

In addition to receiving care for general medical conditions, Covered Persons may receive access to dermatology services, as described below.

Dermatologists provide dermatology consultations to Covered Persons through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the telehealth industry.

In order to receive dermatology consultations, the Covered Person must have completed Teladoc's requirement for access to the general medicine program, including the medical history disclosure form. The Covered Person must also complete a comprehensive Dermatology Intake Form prior to receiving a dermatology consultation. The Dermatology Intake Form consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of his or her condition prior to communicating with a dermatologist. If the Covered Person fails to complete the Dermatology Intake Form or upload the required number of images, the Covered Person will not have access to the dermatologists.

Covered Persons will be allowed to request more than one dermatology consultation at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Initial Consultation: The Covered Person will be required to upload a minimum of three images and a maximum of five images for the dermatologist to review. A dermatologist will respond to the Covered Person's consultation submission via the Teladoc Message Center within two business days of such submission. The dermatologist will either:

1. determine that no additional information is required and provide a diagnosis and prescription, if appropriate; or
2. request additional information from the Covered Person before making a diagnosis.

Covered Person Follow-Up: The Covered Person will have seven days after diagnosis to respond to the dermatologist with follow-up questions via the message center. The Covered Person will be able to respond only once and may upload up to five additional images in the response. The Covered Person will not be charged for a one-time follow-up.

Subsequent Consultations: A Covered Person will have the option of selecting the same dermatologist with whom he or she had a prior consultation or with a new dermatologist licensed in his or her state.

OTHER COVERED EXPENSES

1. Anesthesia and anesthesia services and supplies, including topical and infiltration anesthesia. Services must be rendered by a Qualified Practitioner who is not the operating surgeon or an assistant at the surgery.

2. Treatment by a licensed physical therapist, speech therapist, respiratory therapist or occupational therapist. Speech therapy necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a licensed speech therapist or other Qualified Practitioner, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a congenital anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

3. Aquatic therapy. Benefits apply per designation (e.g. physical therapist, occupational therapist or respiratory therapist). If billed by a physical, occupational or respiratory therapist, benefits are payable as shown under the therapy section of the Schedule of Benefits. All other providers are paid based on the Covered Expenses that are billed.

4. Charges for outpatient cardiac rehabilitation. Limited to Phase II rehabilitation while the Covered Person is in a physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital. Treatment beyond Phase II is not covered. Cardiac rehabilitation while the Covered Person is an Inpatient (Phase I) is covered.

5. Outpatient radiation therapy; chemotherapy.

6. Blood and blood plasma that is not replaced by donation; blood products or extracts and their administration in excess of the first three pints each Calendar Year.

7. Services of a registered nurse (RN) or licensed practical nurse (LPN) for nursing care ordered by Your attending Qualified Practitioner. The nurse must not ordinarily reside in Your home or be a Family Member.

8. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

9. Rental/Purchase of Equipment:

    a. Oxygen and rental of equipment for its administration; rental of equipment to treat respiratory paralysis,

    b. Rental up to the total purchase price or when approved by the Plan for the purchase of a wheelchair, Hospital bed, respirator or other durable medical equipment. The equipment must be needed for therapeutic treatment, be able to withstand repeated use, primarily and customarily used to serve a medical purpose, and not generally useful to a person except for the treatment of a Sickness or Injury. Replacement devices are covered, unless required due to negligence or abuse of the device. Functional repair expenses are covered, unless they are required due to negligent use or abuse of the equipment. Routine maintenance expenses and batteries are not covered, unless stated elsewhere in this Plan. Convenience items, as determined by the Plan, are not covered. Unless approved by the Plan benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

Other Covered Expenses – continued

10. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices are covered, unless required due to negligence or abuse of the device. Functional repairs are covered, unless required due to negligent use or abuse of the device. Routine maintenance expenses are not covered. Dental appliances are not covered.

11. Orthotics. Benefits include the initial purchase, fitting and repair expenses. Replacements are limited to once every five years, unless required due to growth or development. Orthopedic shoes/corrective shoes are not covered, unless they are an integral part of a leg brace.

12. Wigs (cranial prostheses), toupees or hairpieces. Paid as any other In-Network Covered Expense up to $500. Limited to 1 wig per Lifetime. Covered only in the case of sudden onset baldness that is the result of a covered Sickness or Injury, including cancer treatment or a Medically Necessary condition such as alopecia, that is sufficiently extensive to significantly alter Your appearance.

13. Diabetes treatment and diabetic self-management education programs.

14. Diabetic supplies are only covered under the medical Plan if they are not covered under the Prescription Drug Card. Reimbursement under the medical Plan will not be provided if You or a provider request a certain brand that is non-preferred or not covered under the prescription drug program. Supplies that are not covered under the prescription program, such as an insulin pump or a specific brand of glucose meter that communicates with an insulin pump, are reimbursable under the medical Plan. Insulin pumps are limited to one per Calendar Year. Continuous glucose monitors are covered under either the medical Plan or the prescription drug program.

15. Special supplies when prescribed by Your attending Qualified Practitioner and necessary for the continuing treatment of a Sickness or Injury, such as:

    a. catheters;
    b. colostomy bags, belts and rings;
    c. flotation pads;
    d. needles and syringes;
    e. custom-molded orthotic devices; (Over-the-counter orthotics are not covered.)
    f. casts, splints, surgical dressings, trusses, braces and crutches;
    g. oxygen and other gases;
    h. surgical stockings (e.g. Jobst stockings); and
    i. initial contact lenses or eyeglasses following cataract surgery.

    Not Covered: Equipment or supplies to prevent Injury or to facilitate participation in physical activity or sports.

16. Allergy testing and treatment, if it meets the standards of the American Academy of Allergy, Asthma and Immunology (AAAAI). Covered Expenses include initial diagnostic evaluations and diagnostic tests to determine the cause of an allergy and injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis. **The Plan does not cover**: neutralization testing and treatment; repeated intradermal testing, unless documentation indicates the need for continued testing; or skin test end-point titration for evaluating the effectiveness of immunotherapy or food allergy therapy. (Food allergy testing is covered, but not therapy. Sublingual antigen drops are payable as any other Sickness or Injury.)

Other Covered Expenses – continued

17. Infertility. Limited to services performed exclusively to diagnose the cause(s) of infertility. Once a diagnosis has been rendered, no further diagnostic tests are covered, unless they are expected to reveal another clinical cause for infertility. The treatment of infertility is not a Covered Expense.

    Benefits include surgical procedures necessary to repair or restore a malformed or malfunctioning body part or process found to be the cause of infertility, in order to enable natural conception. The Plan does not cover reversals of tubal ligations, reversals of vasectomies, artificial means to achieve pregnancy, genetic testing to diagnose infertility, or other treatment of infertility.

18. Second surgical opinions. The second opinion must be given by a board-certified specialist who, by the nature of his or her specialty, makes him or her qualified to review the procedure that is being proposed. The Qualified Practitioner providing the second opinion must not be associated with the surgeon who initially recommended the surgery. Charges for a third opinion will be covered if the first and second opinions do not agree.

19. Pre-admission testing required in connection with an inpatient Hospital admission for surgery.

20. Hospital admission kits.

21. Routine and non-routine vision exams and related refraction charge.

22. Vision materials. Eyeglasses and contact lenses are payable as shown on the Schedule of Benefits when provided by a licensed optometrist, ophthalmologist or dispensing optician. Benefits include eyeglasses and contact lenses. Subject to the limits shown on the Schedule of Benefits. Benefits for eyeglass lenses include single-vision lenses, bifocals, no-line bifocals and trifocals.

    The Plan does not provide benefits for services or materials connected with:
    a. Customized lenses,
    b. Special scratch-resistant lenses,
    c. Replacement of lost, stolen or broken lenses,
    d. Sunglasses,
    e. Sub-Normal vision aids,
    f. Anti-reflective coating, tinting or ultraviolet protection,
    g. Duplicate or spare items,
    h. Services required for employment, labor agreements or required by any law, or
    i. Lenses, frames or contact lenses furnished or ordered prior to Your effective date under this Plan.

23. Non-routine immunizations and injections, unless stated elsewhere in this Plan.

24. Treatment of nicotine addiction. Payable as shown on the Schedule of Benefits. Benefits include, but are not limited to, counseling sessions, prescription drugs and hypnotism.

25. Services related to the administration of self-injectable specialty medications that are covered under the Prescription Drug Card. Such services are intended to assist the Covered Person and caregivers in the administration of self-injectable specialty drugs. Covered Expenses are limited to one office or outpatient visit and two home health care visits for drug administration training per prescription. After the limit is met, the Specialty drugs must be purchased through the Specialty Pharmacy Program.

26. Routine and non-routine mammograms. 3D mammograms are covered.

Other Covered Expenses – continued

27. Genetic testing or genetic counseling in relation to genetic testing based on Medical Necessity. Genetic testing MUST meet the following requirements:

    The test must not be considered experimental, investigational, or unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

    Genetic testing must also meet at least one of the following:

    a. The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    b. Conventional diagnostic procedures are inconclusive.
    c. The patient has risk factors or a particular family history that indicates a genetic cause.
    d. The patient meets defined criteria that place him or her at high genetic risk for the condition.

28. Routine and non-routine pap smears and pelvic exams.

29. Routine and non-routine PSA tests and prostate exams.

30. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy, CT colonography). Includes routine, non-routine and those requested due to family history. Fecal DNA testing (e.g. Cologuard) is covered as shown on the Schedule of Benefits.

31. Take-home supplies and medications dispensed by the Hospital at the time of Hospital discharge for use at home. This includes discharge from the Emergency room or an Urgent Care center.

32. Home testing and monitoring supplies and equipment, except those prescribed for the treatment of diabetes mellitus and infant apnea.

33. Nutritional counseling and education visits by a registered dietician.

34. Debridement of nails.

35. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

    a. reconstruction of the breast that was removed,
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
    c. prostheses to replace the breast that was removed, and
    d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

    Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the Plan.

36. Nutritional supplements, enteral feedings, vitamins, and electrolytes that are prescribed by a physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a physician and are the sole source of nutrition or are part of a chemotherapy regimen.

Other Covered Expenses – continued

37. Qualifying clinical trials as defined below, including routine patient care costs as defined below incurred during participation in a qualifying clinical trial for the treatment of:

    Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

    Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

    Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

    Routine patient care costs for qualifying clinical trials may include:

    1. Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;

    2. Covered health services required solely for the administration of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

    3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

    Routine costs for clinical trials do not include:

    1. The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;
    2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
    4. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

    With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is 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, and that meets any of the following criteria in the bulleted list below:

    1. Federally funded trials. 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 (NIH), including the National Cancer Institute (NCI);
        b. Centers for Disease Control and Prevention (CDC);
        c. Agency for Healthcare Research and Quality (AHRQ);
        d. Centers for Medicare and Medicaid Services (CMS);
        e. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veteran's Administration (VA);

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
   - It is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
   - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;

4. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The plan sponsor may, at any time, request documentation about the trial; or
5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

38. Telehealth. Covered if made by a Covered Person to a provider or when made by a Covered Person's provider to another provider.

39. Gender Dysphoria. Benefits for the treatment of Gender Dysphoria includes only the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual:

a. Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
b. Cross-sex hormone therapy:
   i. Cross-sex hormone therapy administered by a medical provider (for example, during an office visit)
   ii. Cross-sex hormone therapy dispensed from a pharmacy
c. Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting
d. Laboratory testing to monitor the safety of continuous cross-sex hormone therapy
e. Hair transplantation
f. Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
   i. Male to Female:
      a. Breast augmentation
      b. Clitoroplasty (creation of clitoris)
      c. Labiaplasty (creation of labia)
      d. Laser or electrolysis hair removal in advance of genital reconstruction
      e. Orchiectomy (removal of testicles)
      f. Penectomy (removal of penis)
      g. Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's apple)
      h. Urethroplasty (reconstruction of female urethra)
      i. Vaginoplasty (creation of vagina)
      j. Voice lessons and voice therapy
   ii. Female to Male:
      a. Bilateral mastectomy or breast reduction
      b. Hysterectomy (removal of uterus)
      c. Laser or electrolysis hair removal in advance of genital reconstruction
      d. Metoidioplasty (creation of penis, using clitoris)

Gender Dysphoria – continued

e. Penile prosthesis
f. Phalloplasty (creation of penis)
g. Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
h. Scrotoplasty (creation of scrotum)
i. Testicular prosthesis
j. Urethroplasty (reconstruction of male urethra)
k. Vaginectomy (removal of vagina)
l. Voice lessons and voice therapy
m. Voice modification surgery
n. Vulvectomy (removal of vulva)

The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the covered health services from an available In-Network provider. This travel and lodging assistance applies to the surgeries listed above.

This Plan provides an allowance for Incurred reasonable travel and lodging expense, up to the maximum listed on the Schedule of Benefits, if any, Incurred as a part of the covered health care service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If You would like additional information regarding travel and lodging, You may contact us at www.umr.com or the telephone number on Your ID card.

Coverage does not include procedures that are cosmetic as stated in the Medical Limitations and Exclusions section of this SPD. Cosmetic procedures include, but are not limited to, the following:

a. Abdominoplasty
b. Blepharoplasty
c. Body contouring, such as lipoplasty
d. Brow lift
e. Calf implants
f. Cheek, chin, and nose implants
g. Face lift, forehead lift, or neck tightening
h. Facial bone remodeling for facial feminizations
i. Hair removal
j. Injection of fillers or neurotoxins
k. Laser or electrolysis hair removal not related to genital reconstruction
l. Lip augmentation
m. Lip reduction
n. Liposuction
o. Mastopexy
p. Pectoral implants for chest masculinization
q. Rhinoplasty
r. Skin resurfacing

Other Covered Expenses – continued

40. Treatment of morbid obesity. Payable as shown on the Schedule of Benefits. Covered Expenses include the first morbid obesity surgical consultation visit, even if the surgery itself is not approved as a Covered Expense. If the surgery is approved, all Covered Expenses received in preparation for the surgery (e.g. Qualified Practitioner-guided weight loss program, x- ray/lab tests etc.) will be considered a Covered Expense by the Plan. Your Body Mass Index (BMI) must be at least 50. Surgical treatment is limited to one procedure per Covered Person, per Lifetime. Benefits also include nutritional/educational counseling in connection with the treatment of morbid obesity. Such counseling must be supervised by a Qualified Practitioner.

    Bariatric Surgery: The following criteria will be followed by Utilization Management (UM) to determine coverage:

    1. Your Body Mass Index (BMI) must equal 50 or more;
    2. You must have attempted a physician-guided weight loss program within the past year and for at least a six-month period of time;
    3. There is no specifically correctable cause for obesity or morbid obesity that would otherwise have been covered under the Plan (e.g. an endocrine disorder);
    4. You are at least 25 years of age;
    5. You must be receiving treatment in a surgical program that is experienced in this type of surgery (e.g. a bariatric treatment center). Such program must include all of the following components:

        a. Surgeons experienced with the procedure,
        b. Pre-operative medical consultation and approval,
        c. Pre-operative psychological consultation and approval,
        d. Nutritional counseling,
        e. Exercise counseling,
        f. Psychological counseling, and
        g. Support group meetings;

    Surgical intervention is limited to once per Lifetime. If an urgent or Emergency medical admission is required due to complications of this surgery, this Plan will cover one additional surgical intervention to repair the original surgery.).

41. Orthognathic, prognathic and maxillofacial surgery is covered only when required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment.

42. Sales tax for medical records.

STATE MANDATED BENEFITS

These State mandated benefits are covered subject to the deductible and coinsurance of the Plan, unless shown otherwise on the Schedule of Benefits:

1. Immunizations for any covered Dependent child from birth to the age of six years are payable as shown on the Schedule of Benefits. **This benefit is in addition to any Preventive Care Services or well child care benefit that may be part of this Plan**. Including, but not limited to, the following immunizations:

    a. Diphtheria;
    b. Pertussis;
    c. Tetanus;
    d. Polio;
    e. Measles;
    f. Mumps;
    g. Rubella;
    h. Hemophilus influenza B;
    i. Hepatitis B; and
    j. Varicella.

2. Temporomandibular joint (TMJ) diagnostic, surgical and non-surgical treatment. Benefits include appliances and therapy and steroid joint injections for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary or craniomandibular disorder or other conditions of the jaw joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or treatments thereof. **Benefits do not include the following services for TMJ treatment**: a) services that are unproven or unconventional; b) orthodontic (e.g. braces) and orthognathic treatment for changing Your bite; c) occlusal adjustment or modification of a dental surface to change Your bite; d) restorative therapy or prosthodontic treatment (e.g. use of crowns and bridges to balance the bite); e) ultrasonic treatment, electrogalvanic stimulation, iontophoresis and biofeedback; f) transcutaneous electrical nerve stimulation (TENS); g) nutritional counseling and home therapy programs; h) services to treat a chronic condition for which there is no reasonable expectation of a prompt and predictable improvement in Your health status or i) services that continue after You have reached the expected state of improvement, resolution or stabilization of Your health condition.

3. Services of a Hospital or Ambulatory Surgical Center due to dental care. Anesthetics related to the dental care will also be covered. To be a Covered Expense the services must be provided to:

    - a child under the age of five years,
    - a person with a chronic disability,
    - a person with a medical condition that requires hospitalization for such dental care, or
    - a person with a medical condition that requires general anesthesia for such dental care.

4. Blood lead tests for covered Dependent children under the age of six years, if such tests are not covered under the Preventive Care Services benefit. Payable as shown on the Schedule of Benefits. Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.

State Mandated Benefits - continued

5. Hearing aids, cochlear implants and related treatment for a covered Dependent child under the age of 18 years old, if the child is certified as deaf or hearing impaired by a Qualified Practitioner or audiologist. Covered Expenses include:

   a. the cost of hearing aids and cochlear implants that are prescribed by a Qualified Practitioner or audiologist, in accordance with accepted professional medical or audiological standards;
   b. the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices; and
   c. one hearing aid per ear every three Calendar Years.

6. Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and non-intensive-level services.

   Intensive-level services means evidence-based behavioral therapies that are designed to help a Covered Person with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

   Non-intensive-level services means evidence-based therapy that occurs after the completion of treatment for intensive-level services or, for a Covered Person who has not and will not receive intensive-level services, evidence-based therapy that will improve the Covered Person's condition.

   Intensive-Level Services

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

   a. Based upon a treatment plan developed by a Qualified Practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention;

   b. Implemented by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;

   c. Provided in an environment most conducive to achieving the goals of the Covered Person's treatment plan;

   d. Included training and consultation, participation in team meetings and active involvement of the Covered Person's family and treatment team for implementation of the therapeutic goals developed by the team;

   e. Commenced after a Covered Person is two years of age and before nine years of age; and

   f. The Covered Person is directly observed by the Qualified Practitioner at least once every two months.

Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the Covered Person, regardless of payor, may be applied to the required four years.

The Plan may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for autism spectrum disorders prior to age nine.

Travel time for Qualified Practitioners, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for a Covered Person with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to a Covered Person by a Qualified Practitioner, professional, therapist or paraprofessional in either of the following conditions:

a. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment; or

b. To a Covered Person who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Covered Person's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

a. Based upon a treatment plan developed by a Qualified Practitioner, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention;

b. Implemented by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessional;

c. Provided in an environment most conducive to achieving the goal of the Covered Person's treatment plan;

d. Included training and consultation, participation in team meetings and active involvement of the Covered Person's family in order to implement the therapeutic goals developed by the team; and

e. Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

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

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Travel time for Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan will notify the Covered Person (or their authorized representative) if the level of treatment is transitioning from intensive-level services to non-intensive-level services. The notice will indicate the reason for the transition that may include any of the following:

a. The maximum four-year limit has been met;

b. Intensive-level services are no longer supported by the documentation provided by the Qualified Practitioner; or

c. The Covered Person no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

Intensive-level and non-intensive-level services include, but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under autism spectrum disorders:

a. Acupuncture;
b. Animal-based therapy, including hippotherapy;
c. Auditory integration training;
d. Chelation therapy;
e. Child care fees;
f. Cranial sacral therapy;
g. Custodial or respite care;
h. Hyperbaric oxygen therapy;
i. Special diets or supplements; and
j. Pharmaceuticals and durable medical equipment.

MEDICAL LIMITATIONS AND EXCLUSIONS

This Plan does **not** provide benefits for the following unless stated elsewhere in this Plan:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine; Ayurveda and Ayurvedic nutrition; craniosacral therapy; yoga; homeopathy; movement therapy; naturopathy; tai chi chuan; visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony; chelation (metallic ion therapy) except in the treatment of heavy metal poisoning; rolfing; reiki; reflexology; therapeutic touch; colon therapy; herbal therapy; vitamin therapy; hypnotherapy; guided imagery; meditation; aromatherapy; relaxation techniques; iridology; massage therapy; equine therapy; or

2. **Acupuncture,** except if shown under the Medical Covered Expenses section of this Plan; acupressure.

DENTAL

1. **Dental care** or treatment, except as specifically described; or for orthognathic surgery, including osteotomy procedures of the maxilla and mandible;

2. **Dental and oral surgical procedures involving orthodontic care**;

3. **Preparing the mouth for the fitting of or continued use of dentures**; or

4. **Dental implantology** techniques, including prosthetic devices related to such techniques, except if shown under the Medical Covered Expenses section of this Plan.

DRUGS

1. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a** Qualified Practitioner. Over-The-Counter (OTC) items specifically stated in this plan as a Covered Expense will be covered. When OTC items are provided as a necessary part of a Covered Expense incurred in a Qualified Practitioner's office, Hospital or other facility, they will be covered; or

2. Prescription drugs and supplies are only **covered under the medical Plan if they are not covered under the Prescription Drug Card**. Reimbursement under the medical Plan will not be provided if You or a provider request a certain brand that is non-preferred or not covered under the prescription drug program. Supplies that are not covered under the prescription program, such as an insulin pump or a specific brand of glucose meter that communicates with an insulin pump, are reimbursable under the medical Plan.

EXPERIMENTAL OR UNPROVEN SERVICES

Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

1. Items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials, unless identified as a Covered Expense elsewhere in this Plan. (This exclusion does not apply to investigational new drugs which have reached a Phase 3 clinical testing for the treatment of HIV infection.)

Medical Limitations and Exclusions - continued

2. Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

3. Items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

4. Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

If You have a life threatening condition (e.g. likely to cause death within one year), the Plan may provide coverage for a treatment that would otherwise be excluded under this provision. The Plan reserves sole discretion to make this determination. Such coverage will only be approved if a treatment is provided under a specific research protocol that meets standards equal to those of the National Institutes of Health and has shown promise in limited use.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to Injury, infection or other disease of the involved part is a Covered Expense when the need for such surgery is not the result of, or a complication of, a prior cosmetic procedure;

2. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;

3. Treatment or services for **weight control or reduction**. Treatment includes, but is not limited to: nutritional or diet supplements; dietary or nutritional counseling (except as covered elsewhere in this Plan); individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; physical fitness programs. Treatment or services covered elsewhere in this Plan or required by Health Care Reform are Covered Expenses; or

4. Treatment of **obesity or morbid obesity or for weight reduction,** except if shown under the Medical Covered Expenses section of this Plan**.**

PROVIDERS

1. Any service or supply:

   a. provided while You are **not under the regular care of a Qualified Practitioner**,
   b. **not authorized or prescribed by a Qualified Practitioner**, or
   c. authorized or prescribed by a Qualified Practitioner, but **excluded under this Plan;**

2. Services provided by a **person who ordinarily resides in Your home** or who is a Family Member;

3. Any costs of an **appointment You did not attend**; charges for copying and providing medical or any other type of information in support of a claim; completion of claim forms or forms necessary for Your return to work or school;

4. **Private duty nursing**;

5. Charges for a **standby surgical team**, unless surgery is actually performed; or

6. **Services of a second surgeon or surgical assistant**, unless required for the safe and effective performance of a covered surgical procedure.

REPRODUCTION

1. **Elective abortions** performed by any means including surgical and pharmaceutical methods. (Note: Abortions when the life of the mother or baby is in danger or due to rape or incest will be covered.) (Complications of elective abortions are covered the same as any Sickness or Injury.)

2. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs, except as stated under the Other Covered Expenses section of this Plan;

3. The **reversal of voluntary sterilization** procedures;

4. **Home births** and associated costs;

5. **Amniocentesis, chorionic villi sampling or ultrasound** performed to alleviate anxiety or to determine the gender of the fetus;

6. **Childbirth education or preparation courses** (e.g. Lamaze classes);

7. Treatment of a **sexual dysfunction.** Surgical treatment is not covered. Non-surgical treatment is not covered. Counseling is not covered. (The Plan will cover office visits up to the diagnosis of sexual dysfunction, but not office visits for treatment. It will also cover the diagnostic tests, up to the diagnosis of the medical condition causing erectile dysfunction if diagnosed.); or

8. **Gestational or surrogate services,** including 1) inpatient or outpatient prenatal care and/or preventive care, 2) screenings and/or diagnostic testing, and 3) delivery and post-natal care. The exclusion for health care services listed above does not apply when the gestational carrier or surrogate is a Covered Person. Any fees are not covered, including: 1) screening, hiring and compensation of a gestational carrier or surrogate, including surrogacy agency fees; 2) surrogate insurance premiums; and 3) travel or transportation fees.

ROUTINE AND GENERAL HEALTH

1. **Vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders, multi-focal intraocular lenses following cataract surgery. This exclusion does not apply to aphakia patients. The purchase of soft lenses or sclera shells for use with corneal bandages are Covered Expenses. Eye refractions and the initial purchase of eyeglasses or contact lenses after a cataract surgery are Covered Expenses. **(Note**: vision exams, eyeglasses and contact lenses are payable as shown on the Schedule of Benefits.)

2. **Hearing aids.** Hearing exams or tests administered directly or indirectly for fitting a hearing aid or device except if shown as covered in the Medical Covered Expenses section of this Plan. Certain hearing aids, cochlear implants and related treatment are payable if shown in the State Mandated benefit section of the Plan. Bone-anchored hearing aids for Covered Persons under age 18 are a Covered Expense. The repair of any hearing aid is not a Covered Expense.

3. **Third party exams**, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law unless required by state mandate; routine physical exams for occupation, employment, travel or the purchase of insurance, except as shown under the Preventive Care Services benefit; (**Note**: Immunizations for foreign travel are covered as shown under the Preventive Care Services benefit. Third party exams for school, sports and camp for Dependent children are covered as shown under the "For Children" section of the Preventive Care Services benefit.);

4. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction, except as stated under the Other Covered Expenses;

5. **Routine foot care**, except when You have a medical diagnosis, such as, but not limited to, diabetes, peripheral neuropathies or arteriosclerosis, or as specifically stated under the Other Covered Expenses. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis and nail trimming; or

6. Services or supplies for **physical fitness, wellness, health education, nutritional or dietary supplements or personal hygiene.** Certain services may be payable as shown in the Schedule of Benefits.

SERVICES UNDER ANOTHER PLAN

1. Any Sickness or Injury arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which You would not be required to pay if You did not have this coverage;

3. Any charges that **would have been paid by Your primary plan** had You complied with all of the prior authorization or pre-certification requirements of that plan;

4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include Medicare or Medicaid);

Medical Limitations and Exclusions – continued

5. Any service or supply provided in the care of any service related Sickness or Injury (past or present) **if You are in a Hospital or facility owned or operated by the United States Government** or any of its agencies; or

6. Services that Your Dependent child's **school is legally obligated to provide**, whether or not the school actually provides them and whether or not You choose to use those services.

OTHER

1. **Excess charges** or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act;

2. Services **not Medically Necessary** for diagnosis and treatment of a Sickness or Injury;

3. Occupational, physical, or speech therapy services related to **Developmental Delays, intellectual disability, or behavioral therapy,** unless stated elsewhere in this Plan;

4. **Custodial care; rest cures;**

5. Any medical expense incurred **before Your Plan effective date of coverage** or **after the date Your coverage under the Plan terminates**, except as specifically described; any medical **expenses incurred while You are not covered** under this Plan;

6. Charges incurred **outside the United States** if You traveled to such location to obtain the service, drug or supply. (If You are traveling on vacation, Covered Expenses due to Sickness or Injury are payable under the Plan.)

7. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony**; any medical expense related to engaging in an **illegal act or occupation**, **riot or public disturbance**;

8. **Acts of War.** Sickness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;

9. **Educational testing or training or recreational therapy**; **vocational training** programs;

10. **Treatments aimed at the development or acquisition** of a functional ability that has not previously been achieved, except as stated under the Other Covered Expenses;

11. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;

12. Inpatient Hospital admissions which are primarily for physical, speech or occupational therapy or for x-ray or radiation therapy;

13. Services or supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, academic institution or similar person or group;

Medical Limitations and Exclusions – continued

14. **Exclusions,** including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan;

15. Charges for **legal services**;

16. **Charges for travel,** except as stated under the Ambulance Service Benefit and the Transplants Travel and Lodging benefit; **charges for lodging**, except as stated under the Transplants Travel and Lodging benefit;

17. **Repairs or replacements** of durable medical equipment, orthotics, prosthetics, or prescription drugs due to accidental loss, theft, or negligent misuse, unless covered elsewhere in this Plan;

18. Charges for **services to educate You or help You adapt to a diagnosis or a chronic physical or mental condition,** except as stated for diabetic self-management education programs;

19. **Immunizations and health services** for licensing, employment and insurance purposes;

20. **Services to improve an existing physical or mental state in the absence of a Sickness or Injury,** except as specifically stated otherwise for the treatment of Autism Spectrum Disorders or unless covered elsewhere in this Plan;

21. Services or supplies **for the convenience** of the patient, the Qualified Practitioner, the patient's family or any other person. Any treatment that is provided mainly for a member's vocation, comfort, convenience, exercise, physical fitness or recreation. Any treatment that is provided mainly as a part of the Covered Person's environment and is a common household item. This applies to any procedure, service, device, supply, durable medical equipment, prosthetic devices, and technology;

22. **Services or treatments that continue after You have reached the expected state of improvement, resolution or stabilization** of a Sickness or Injury**,** except as specifically stated otherwise for the treatment of Autism Spectrum Disorders or unless covered elsewhere in this Plan;

23. **Items that are useful in the absence of a Sickness, Injury or disability.** Including, but not limited to air conditioners, air cleaners and purifiers, humidifiers, whirlpools, dehumidifiers, lift chairs, stair lifts, van lifts, physical fitness items, such as exercise cycles and other similar items for **personal comfort**, **personal hygiene, physical fitness or convenience**;

24. Any charges resulting from Your **admission to a Hospital or Qualified Treatment Facility on a Friday, Saturday or Sunday**, unless Your admission is on an Emergency basis or treatment or surgery is scheduled to be performed within 24 hours of Your admission;

25. Services for the **treatment of sleep disorders**;

26. Charges for **marriage counseling**;

27. Additional costs and/or care related to **Wrong Surgeries**. Wrong Surgeries include, but are not limited to, surgery performed on the wrong body part and/or surgery performed on the wrong person;

28. **Sales taxes and shipping and handling charges**, unless covered elsewhere in this Plan; or

29. **Court ordered examinations or counseling** unless required by state mandate.

PRESCRIPTION DRUG CARD

A directory of participating pharmacies is available on the Drug Card's website.

Covered Drugs

Your medical ID card is also used to obtain prescription drugs. This card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." Your pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on Your ID card.

How To Use Your ID Card

Present Your medical ID Card and the prescription to a participating pharmacy. Then pay the pharmacist the cost shown on the Schedule of Benefits.

If You are without Your medical ID Card or at a non-participating pharmacy, You may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are on the Drug Card's website or through the WCA Group Health Trust.

Mail Order Drug Service

If You are using an ongoing prescription drug, You may purchase that drug on a mail order basis. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis. Specialty drugs can only be obtained through mail order and are subject to a maximum 30-day supply per prescription.

The cost for mail order prescriptions is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card website or from the WCA Group Health Trust. All prescriptions will be mailed directly to Your home.

Prior Authorization

Before certain prescription drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain prior authorization.

Non-Specialty Prior Authorization
All non-specialty prior authorizations will be handled by CVS Caremark. Contact the CVS Prior Authorization Department at:
Phone: 1-800-294-5979
Fax: 1-888-836-0730

Specialty Prior Authorization
All specialty prior authorizations will be handled by National CooperativeRx. Contact National CooperativeRx at:
Phone: 1-608-416-8702 or toll free 1-877-205-6592
Fax: 1-866-278-8190

SECTION 2 DEFINITIONS

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the Plan. Defined words are capitalized throughout the Plan.

Accident
A happening by chance and without intention or design, which is unforeseen, unexpected and unusual at the time it occurs.

Actively at Work
An Employee is Actively at Work if he or she is employed by the Employer on a regular basis and meets the minimum requirements set by the Employer for eligibility under the Plan. An Employee is not considered Actively at Work if he or she has been laid off or is absent from work for reasons other than those which entitle the Employee to leave under family and medical leave laws or a Health Factor, and such layoff or absence from work is for such a period of time that the Employee is no longer eligible for the benefits of this Plan pursuant to the rules or policies established by the Employer. Status of employment on a regular basis is determined by the Employer.

Ambulatory Surgical Center
Any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery and does not provide services or accommodations for patients to stay overnight.

Amendment
A document, duly authorized by the Plan Administrator, which changes any provision of the Plan.

Ancillary Services
Services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by Out-of-Network Qualified Practitioners at In-Network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an Out-of-Network Qualified Practitioner when an In-Network Qualified Practitioner is not available.

Birthing Center
A licensed facility which: a) provides prenatal care, delivery and immediate postpartum care, and care of a child born at the Birthing Center; b) is directed by a Qualified Practitioner specializing in obstetrics and gynecology; c) has a Qualified Practitioner or certified nurse-midwife present at all births and during the immediate postpartum period; d) extends staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area; e) has at least two beds or birthing rooms for use by patients during labor and delivery; f) provides full-time skilled nursing services (directed by a RN or certified nurse-midwife) in the delivery and recovery rooms; g) provides diagnostic x-ray and laboratory services for the mother and newborn; h) has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); i) is equipped and staffed to handle medical emergencies and provide immediate life support measures; j) accepts only patients with low risk pregnancies; k) has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure; l) provides an ongoing quality assurance program; and m) keeps a medical record for each patient.

Definitions - continued

Business Associate
A Business Associate is a person who provides, other than in the capacity of a Plan Employee, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Plan where the provision of the service involves the disclosure of individually identifiable health information from the Plan or from another Business Associate to the person.

Calendar Year
A 12 month period of time that starts on January 1 and ends on December 31.

Center of Excellence
A contracted facility that offers superior care at a discounted rate for major procedures such as transplants.

Chronic Disability
A disability which meets all of the following requirements: a) it is attributable to a mental or physical impairment or combination of mental and physical impairments; b) it is likely to continue indefinitely; and c) it results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living and economic self-sufficiency.

Claims Administrator
UMR, Inc.

Complications of Pregnancy
A Sickness or Injury superimposed upon an otherwise normal pregnancy. The Sickness or Injury must have the potential to affect the course or outcome of the pregnancy, or the health of the mother or fetus. Examples of Complications of Pregnancy are preeclampsia, toxemia, gestational diabetes, hyperemesis, gravidarium, ectopic pregnancy, miscarriage and gynecological surgery performed in the six-week postpartum period (other than elective sterilization) if the surgery is in connection with or results from the pregnancy. Complications do not include false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness and similar conditions associated with a difficult pregnancy.

Confinement
Being a patient in a Hospital for at least 24 consecutive hours per day or being a patient in a Skilled Nursing Facility or other Qualified Treatment Facility 24 hours a day. Confinement starts with Your admission to a Hospital or other Qualified Treatment Facility and ends with Your discharge from such facility. Generally, successive Confinements are considered one Confinement if they are:

1. Due to the same Sickness or Injury; and

2. Separated by fewer than 30 consecutive days when You are not confined.

If You experience an unexpected recurrence of Your original Sickness or Injury after recovery or You have a new Sickness or Injury, the Plan Administrator may determine that You are entitled to a new period of Confinement.

In all cases, the Plan Administrator determines whether a subsequent confinement is the same period of Confinement or a new period of Confinement.

Definitions - continued

Convenient Care Clinic
Health clinics located in retail stores, supermarkets or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family illnesses such as sore throats, ear infections, colds or coughs. Such a clinic must be operating under applicable state and local regulations and overseen by a physician where required by law.

County
The County or other governmental unit, identified on the cover page, which employs the Covered Employee.

Covered Dependent
An Employee's eligible Dependent who is covered under this Plan.

Covered Employee
An Employee who is eligible and covered under this Plan.

Covered Expense
Expense Incurred by You or Your Covered Dependent for services or supplies provided by a Qualified Practitioner or Qualified Treatment Facility due to a Sickness or Injury if the Expense Incurred is covered by the Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section.

Covered Person
An Employee or Dependent who is covered under this Plan.

Custodial Care
Care to assist in the activities of daily living and care that is not likely to improve Your medical condition.

Dependent
1. A Covered Employee's legal spouse.

2. A Covered Employee's married or unmarried child whose age is less than the limiting age and is a: natural born, blood-related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support.

   For purposes of Plan eligibility, a step-child generally is a child of a Covered Employee's spouse who has not been legally adopted by the Covered Employee. If the Covered Employee and the spouse become divorced, or the Covered Employee and / or spouse die, that child will cease being treated as a step-child under the Plan and will lose coverage under the Plan as of the date of final divorce between You and the biological parent, the end of the month in which the biological parent dies, or the end of the month in which the child reaches the limiting age, subject to any continuation rights which are available to the child.

   The limiting age for a Dependent child is the last day of the month in which the child reaches age 26.

Definition of Dependent – continued

Coverage may be extended (beyond age 26) for a Dependent child if **all** of the following requirements are met:

a. the Dependent child is a full-time student, regardless of age, and
b. the Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
c. the Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Sickness or Injury may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

a. the date the child's coverage would terminate for reasons other than not being a full-time student,
b. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

3. A Covered Employee's grandchild, as long as the Employee's Covered Dependent child or legal ward, who is the parent of the grandchild, is not yet 18 years old, or marries, whichever occurs first.

A Covered Dependent child who attains a limiting age while covered under this Plan will remain eligible for benefits if the Plan Administrator determines that all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;

2. The child is incapable of self-sustaining employment because of intellectual disability or physical handicap;

3. The child is chiefly dependent on the Covered Employee for support and maintenance; and

4. The child never married.

You must provide satisfactory proof that the above conditions exist within 30 days after the date the limiting age is reached. The Plan Administrator may request such proof annually after two years from the date the limiting age is reached. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

No person may be covered as both an Employee and a Dependent at the same time. If both the Employee and spouse are eligible for coverage under this Plan, only one may enroll for Dependent coverage. (When the Employer employs both an Employee and the Employee's Covered Dependents, only one plan is permitted per Covered Family. Two individual plans or double coverage is not allowed.)

Right To Check Dependent Eligibility
The Plan reserves the right to check the eligibility status of a spouse or Dependent child(ren) at any time during the year. You and Your Dependent have an obligation to notify the Plan when the Dependent's eligibility status changes during the year. Please notify Your Employer of any status changes.

Definitions – continued

Developmental Delays
Conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Disability or Disabled
The inability of an Employee to perform adequately the material and substantial duties of his or her regular occupation due to involuntary, medically proven and documented physical or mental impairment(s). The physical or mental impairment(s) causing the Disability must be substantiated in objective, contemporaneous medical records and documentation. For purposes of this definition, the regular occupation is the position that the Covered Employee held on the date that the Plan Administrator determines to be the first day on which the Employee was disabled.

Effective Date
The effective date stated on the cover of this Plan.

Emergency
Any Sickness or Injury which requires immediate treatment and which if not immediately treated would jeopardize or impair the health of the Covered Person. An Emergency may or may not be life threatening. A condition is considered to be an Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

Employee
You, when You are employed in a regular full-time or part-time benefit-eligible position, as classified by the Employer, paid a salary or earnings by the Employer, and Actively at Work. For purposes of this Plan, Employee does not include independent contractors, leased Employees, temporary Employees or Employees in unallocated positions as determined by the Employer.

Employer
The public entity that employs the Covered Employee.

Enrollment Date
Your effective date of coverage under this Plan.

Essential Health Benefits
If the Plan covers services that are included under the following categories, as defined under the Patient Protection and Affordable Care Act, the Plan may not place annual or Lifetime dollar limits on such services: ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, etc.

Definitions – continued

Expense Incurred
The amount charged for services and supplies needed to treat the Sickness or Injury. The Expense Incurred date is the date a supply or service is provided.

Family
A Covered Employee and the Covered Employee's Covered Dependents.

Family Member
Your lawful spouse and Dependent child(ren) or any person related in the same way to Your covered Dependent.

Gender Dysphoria
A disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Genetic Information
Genetic Information refers to the following:

1. Your own genetic tests;
2. The genetic tests of Your Family Members;
3. A disease or disorder in Your Family Members;
4. Your family history;
5. Genetic information of any fetus of a pregnant woman;
6. When related to the use of assisted reproductive technology, it means the genetic information of an embryo legally held by You or a Family Member;
7. Your Family Members who are first-degree, second-degree, third-degree or fourth-degree relatives to You or Your Dependent; and
8. Your participation in clinical research involving genetic services.

Health Factor
The health status, medical condition, claims experience, receipt of health care, medical history, genetic information; whether an individual is a victim of domestic violence or engages in activities such as motorcycling, horseback riding, snowmobiling or similar activities; or disability of any Employee or Dependent of any Employee.

Home Health Care
A formal program of care and intermittent treatment that is: performed in the home; prescribed by a Qualified Practitioner; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or Skilled Nursing Facility stay or results in a shorter Hospital or Skilled Nursing Facility stay; organized, administered, and supervised by a Hospital or qualified licensed providers under the medical direction of a Qualified Practitioner; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

Definition of Home Health Care – continued

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care (e.g. care that is not provided on a continuous, non-interrupted basis).

Home Health Care Agency
A public or private agency or organization which:

1. Specializes in providing medical care and treatment in the home;

2. Is primarily engaged in providing skilled nursing services and other therapeutic services;

3. Is duly licensed by all appropriate authorities;

4. Has a professional group associated with the agency or organization, which includes at least one registered nurse (RN), and establishes policies to govern the services provided;

5. Has a Qualified Practitioner or registered nurse (RN) providing full-time supervision of the services provided;

6. Maintains a complete medical record on each patient;

7. Has a full-time administrator; and

8. Is certified by Medicare.

Home Health Care Plan
A formal, written plan made by the Covered Person's Qualified Practitioner that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital Confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care
Palliative and supportive care to terminally ill patients and their families.

Hospice Care Agency
An agency which:
1. has the primary purpose of providing Hospice Care to hospice patients;

2. is licensed and operated according to the laws of the state in which it is located;

3. has obtained any required certificate of need;

4. provides 24-hour-a-day, seven-day-a-week service, supervised by a Qualified Practitioner;

5. has a full-time coordinator;

6. keeps written records of services provided to each patient;

Definition of Hospice Care Agency – continued

7. has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients;

8. has a licensed social service coordinator;

9. establishes policies for the provision of Hospice Care; assesses the patient's medical and social needs and develops a program to meet those needs;

10. provides an ongoing quality assurance program;

11. permits area medical personnel to use its services for their patients; and

12. uses volunteers trained in care and services for non-medical needs.

Hospice Care Program
A written plan of Hospice Care which is established and reviewed by a Qualified Practitioner and the Hospice Care Agency, and describes palliative and supportive care to hospice patients and their Immediate Families.

Hospice Facility
A licensed facility or part of a facility which:

1. principally provides Hospice Care;

2. has 24 hour a day nursing services, provided under the direction of a registered nurse (RN);

3. has a full-time administrator;

4. keeps medical records of each patient;

5. has an ongoing quality assurance program; and

6. has a Qualified Practitioner on call at all times.

Hospital
An institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a Qualified Practitioner and surgeon in regular attendance;

3. Provides continuous 24-hour-a-day nursing services;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where it is located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Definition of Hospital– continued

Hospital does **not** include an institution which is principally a rest home, nursing home, convalescent home or a home for the aged, clinics, free-standing surgical center, facilities that provide primarily rehabilitative, education or custodial care, health resorts, spas or sanitariums. Hospital does **not** include a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

Immediate Family
Your spouse, children, parents, grandparents, brothers and sisters and their spouses. (For Hospice Care only, Your Immediate Family is Your parent, spouse and Dependent Children.)

Injury
Physical damage to Your body caused by an external force and due, directly and independently of all other causes, to an Accident.

Inpatient Treatment
Treatment while confined as a patient in a Hospital or Qualified Treatment Facility. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 24 hours.

Late Applicant
An Employee who enrolls for coverage more than 30 days after they are eligible to be covered. A Dependent who is enrolled for coverage more than 30 days (one year for a newborn child or an adopted child) after they are eligible to be covered.

Lifetime
When used in reference to benefit maximums and limitations, the time You are covered under this Plan, whether or not Your coverage under the Plan is continuous.

Medical Condition
A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Medical Specialty Medications
Medical Specialty Medications (including gene therapy and CAR-T therapy) are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary
Medically Necessary means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that generally meet the following criteria, as determined by the Plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and

Definition of Medically Necessary – continued

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

3. Not mainly for Your convenience or that of Your Qualified Practitioner; and

4. Is the most appropriate care, supply, or drug that can be safely provided to the member and that is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Sickness, Injury or symptoms; and

5. Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a physician or Qualified Practitioner has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time) are available to Covered Persons by calling UMR, at the telephone number on Your ID card, and to Qualified Practitioners, physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as amended.

Negotiated Rate
The amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefits
Any Covered Expense that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Definitions – continued

Outpatient Treatment
Treatment received while not confined in a Hospital or Qualified Treatment Facility, including diagnostic laboratory examinations and psychological testing.

Pediatric Services
Services provided to a Covered Person under 19 years of age.

Plan
The medical plan benefits described in this document and including any schedules, attachments and Amendments to this document. Prior, current and successive plans will be considered one plan and not separate and distinct plans.

Plan Administrator or Trust
WCA Group Health Trust.

Plan Sponsor
The Plan Sponsor of the Plan is WCA Group Health Trust.

Post-Service Claim
Any claim that is not a Pre-Service Claim.

Pre-Determination
A Pre-Determination is a review of benefits by the Claims Administrator, on behalf of the plan, prior to services being provided. Although this review is not required by the plan, a covered person or provider may voluntarily request a review. A covered person or provider may wish to request a review before incurring medical expenses. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure, service or supply is generally a covered benefit under the plan. Since a Pre-Determination is done prior to a service, it is not a claim, and therefore may not be appealed. If the results of the review conclude that a procedure or service may be covered under the plan, it does not guarantee the plan will ultimately pay the claim if the claim differs from the Pre-Determination request that was submitted. All plan terms and conditions will still be applied when determining whether a claim is payable under the plan.

Preferred Provider Organization (PPO)
When a provider has contracted with a Preferred Provider Organization network, they are an In-Network provider. In-Network providers generally furnish services at a discounted rate to the Plan. If a provider has not contracted with the PPO network, they are an Out-of-Network provider.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the Plan for the medical care.

Prior Authorization
The process of determining benefit coverage prior to service being rendered to a Covered Person. A determination is made based on Medical Necessity (Medically Necessary) criteria for services, tests or procedures that are appropriate and cost-effective for the Covered Person. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Protected Health Information
Protected Health Information means individually identifiable health information that is: transmitted or maintained in any form or medium; is created or received by a health care provider, the Plan, an Employee or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual.

Prudent Layperson
A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified High Deductible Health Plan (QHDHP)
A health plan that meets the IRS requirements of a High Deductible Health Plan with respect to Deductibles and out-of-pocket amounts for the purpose of being able to contribute to a Health Savings Account (HSA).

Qualified Practitioner
A provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan. A Qualified Practitioner's services are not covered if the practitioner resides in Your home or is a Family Member.

Qualified Treatment Facility
A duly licensed facility, institution or clinic, operating within the scope of its license.

Recognized Amount
In the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Copays, Coinsurance, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

1. Non-network Emergency health services.
2. Non-Emergency covered health services received at certain network facilities by Out-of-Network Qualified Practitioners, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

Definition of Recognized Amount - continued

The amount is based on either:

1. an All Payer Model Agreement if adopted,
2. state law, or
3. the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by an Out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Sickness

1. A disease or disturbance in function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of Your body;

2. Muscle tiredness or soreness resulting from overexertion in a physical activity; or

3. Pregnancy.

Site of Care

The treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Skilled Nursing Facility

A facility that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;

2. A Qualified Practitioner's services available at all times;

3. A registered nurse (RN) or Qualified Practitioner in charge and on full-time duty. With one or more registered nurses (RNs) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care during convalescence from Sickness or Injury.

A Skilled Nursing Facility is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Skilled Nursing Facility Confinement

Skilled Nursing Facility Confinement is only a Confinement in a Skilled Nursing Facility which:

1. Begins while You or Your covered Dependent are covered under this Plan;

Definition of Skilled Nursing Facility Confinement - continued

2. Is necessary for care or treatment of the same Sickness or Injury which caused the prior Hospital Confinement; and

3. Occurs while You or Your covered Dependent are under the regular care of the Qualified Practitioner who certified the required Skilled Nursing Facility Confinement.

Note: A period of "Confinement" is defined as shown in this Plan.

Telehealth
The practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a physician.

Transitional Treatment
Treatment for nervous or mental disorders, alcoholism or other drug abuse that is provided in a less restrictive manner than Inpatient Treatment, but in a more intensive manner than Outpatient Treatment.

Urgent Care
Any care that in the opinion of Your Qualified Practitioner is an urgent situation. Any care that the use of non-urgent care time frames would put Your life, health or ability to regain maximum function at risk.

Usual and Customary
The amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You and Your
You as the Covered Employee and any of Your Covered Dependents, unless otherwise provided.

SECTION 3 ELIGIBILITY

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to Employees hired on or after the effective date of this Plan. The Dependent Coverage section applies to Dependents that are added on or after the effective date of this Plan.

Employees who were covered under any plan that this Plan replaces will be covered on the effective date of this Plan. Coverage will include Dependents of such an Employee. You must have met the eligibility requirements of the Plan.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the Plan if You are an Employee who meets the eligibility requirements of Your Employer. The effective date of Your coverage is when You satisfy the eligibility period as determined by Your Employer.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms furnished and accepted by UMR, Inc. Each Employee's effective date of coverage is determined as follows:

1. If Your completed enrollment forms are received by UMR, Inc. within 30 days of Your eligibility date, Your coverage is effective on Your eligibility date.

2. If Your completed enrollment forms are received by UMR, Inc. **more than** 30 days after Your eligibility date, this is considered **late enrollment**. You will not be eligible to enroll for coverage until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Employee coverage will begin at 12:01 AM, Standard Time, on Your effective date. You must actually begin performing work with the Employer before coverage will be effective under the Plan.

Eligible Employees working less than 30 hours per week (less than the 75% FTE employee allocation) who have their employee allocation increased to 75% FTE or greater will be offered health insurance. The employee allocation increase must be the result of additional work lasting at least 12 months. To qualify, an Employee must enroll for coverage within 30 calendar days from the date of the employee allocation increase. Coverage will become effective on the first day of the month following receipt of the completed enrollment form. If coverage is waived at this time, You will not be eligible to enroll for coverage under this Plan until the next Annual Open Enrollment Period, except as stated under the "Changes in Status" or "Special Enrollment Rights" sections of this Plan.

Eligible Employees working 30 hours per week or more (75% or more FTE employee allocation) who declined health insurance are eligible to enroll for coverage if their Employee allocation increases to full-time (100% FTE employee allocation). The employee allocation increase must be the result of additional work lasting at least 12 months. To qualify, an Employee must enroll for coverage within 30 calendar days of the date of the employee allocation increase. Coverage will become effective on the first day of the month following receipt of the completed enrollment form. If coverage is waived at this time, You will not be eligible to enroll for coverage under this Plan until the next Annual Open Enrollment Period, except as stated under the "Changes in Status" or "Special Enrollment Rights" sections of this Plan.

Please refer to the **Special Enrollment Rights** section of this Plan for additional enrollment rights and events.

DEPENDENT ELIGIBILITY

Each Dependent is eligible for coverage on the later of:

1. The date the Employee is eligible for coverage, if the Employee has Dependents on that date;

2. The date of the Covered Employee's marriage for any Dependents acquired on that date;

3. The date of birth of the Covered Person's natural born child;

4. The date a valid court order is issued which, by federal law or Plan provision, requires the Plan to provide coverage;

5. For an adopted child: An adopted child is eligible for coverage on the date that a court makes a final order granting adoption or on the date that the child is legally placed with the Covered Employee for adoption, whichever is earlier. Coverage for the adopted child will begin on the date of eligibility if the required enrollment form for the adopted child is received by the Plan Administrator within 60 days of that date; or

6. For a legal ward: A legal ward is eligible for coverage on the date established by the court order as the date which You begin guardianship. Coverage for the legal ward will begin on the date he or she became eligible. The Plan Administrator must receive the required enrollment form to add the legal ward within 30 days after he or she first became eligible.

Dependents of an Employee may be covered only if the Employee is also covered.

If both the Employee and a Dependent are eligible for Employee coverage under this Plan, as defined by Your Employer, each Covered Expense is payable only once and each Covered Person is covered only once. (When the Employer employs both an Employee and the Employee's Covered Dependents, only one plan is permitted per Covered Family. Two individual plans or double coverage is not allowed.)

DEPENDENT EFFECTIVE DATE OF COVERAGE

Each Dependent's effective date of coverage is determined as follows:

1. If a Dependent's completed enrollment forms are received by the Plan Administrator within 30 days of the Dependent's eligibility date, that Dependent is covered on his or her eligibility date.

2. An eligible newborn of a Covered Person is covered if enrolled within 60 days of birth. In no case will a newborn's enrollment be accepted if received more than one year following the birth unless added during open enrollment or if a special enrollment event occurs.

3. If You marry after Your coverage is effective, You must apply for family coverage within 30 days of Your marriage. If You do, Your family coverage becomes effective on the date of the marriage.

4. If a Dependent's completed enrollment forms are received by the Plan Administrator more than 30 days after the Dependent's eligibility date, this is considered **late enrollment**. Such Dependent will not be eligible to enroll for coverage until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Dependent coverage will begin at 12:01 AM, Standard Time, on the Dependent's effective date of coverage under the Plan.

Please refer to the **Special Enrollment Rights** section of this Plan for additional enrollment rights and events.

RETIREE COVERAGE

Effective January 1, 2012, this Plan does not offer Retiree Coverage. However, if You were covered under Retiree Coverage prior to January 1, 2012, You are eligible for coverage under this Plan until You are Medicare eligible or You reach age 65, whichever occurs first.

ANNUAL OPEN ENROLLMENT PERIOD

Each year Your Employer will provide an enrollment period. Once You have made elections for the year, Your choices cannot be changed until the next Annual Open Enrollment Period, except as shown in the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Completed enrollment forms must be received by the Plan Administrator before the end of the Annual Open Enrollment Period. If Your completed enrollment form is not received by that time, You will not be able to enroll in the Plan or make changes until the next Annual Open Enrollment Period, except as shown in the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Your Employer will notify You of the dates of the Annual Open Enrollment Period each year.

Note: The Annual Open Enrollment Period does not apply to Retiree Coverage, if offered.

Changes In Status

If You have a change in status, as defined by the IRS, You have 30 days from the date of that change to make new elections under this Plan. Any changes in Your elections must be consistent with Your change in status or they will not be allowed. Change in status means only a change as stated below.

1. **Legal Marital Status**. Your marriage, divorce, annulment or the death of Your legal spouse;

2. **Number of Dependents**. An increase or decrease in the number of Dependents You have due to birth, adoption, placement for adoption or the death of a Dependent;

3. **Employment Status**. Any of the following events that change the employment status of You or Your Dependent, including termination or commencement of employment, strike or lockout, of commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;

   If You declined coverage under this Plan due to coverage under another plan or because of the pro-rated premium contribution required of part-time Employees, a special enrollment period may be permitted. Eligible Employees working 30 hours or more per week (75% or more FTE employee allocation) who declined health insurance are eligible to enroll if their employee allocation increases to full-time (100% FTE employee allocation).

   The employee allocation increase must be the result of additional work lasting at least 12 months. To qualify, an Employee must enroll for coverage within 30 calendar days from the date of the employee allocation increase. Coverage will become effective on the first day of the month following receipt of the completed enrollment form.

4. **Dependent Status**. Your Dependent satisfies or ceases to satisfy eligibility requirements for coverage;

Changes in Status – continued

5. **Residence**. Any change in residence for You or Your Dependent (must affect eligibility);

6. **FMLA Leave Status**. At the time a leave under the FMLA begins, the Employee may change elections to the extent allowed under the federal *Family and Medical Leave Act;*

7. **COBRA Continuation**. You or Your Dependent become eligible for and elect continuation coverage under the Employer's group health plan as provided by *COBRA* or a similar State law;

8. **Judgment, Decree or Court Order**. An order resulting from a divorce, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires *You* or another individual to provide health coverage for Your Dependent child;

9. **Entitlement to Medicare or Medicaid**. A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for You or Your Dependent;

10. **HIPAA Special Enrollment Rights**. An event which qualifies as a special enrollment right under the *Health Insurance Portability and Accountability Act*;

11. **Significant Cost Increase**. Election changes are limited to increasing Your election to cover the cost increase or changing the election to provide for a similar benefit offered by Your Employer;

12. **Significant Curtailment of Coverage**. An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;

13. **Addition or Elimination of a Benefit Option.** Employees can choose any of the Plans offered to them unless limited by their Employer;

14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of Your spouse's, ex-spouse's or other Dependent's employer. To qualify as a change in status under this plan the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If You have questions regarding whether an event qualifies as a change in status, the Claims Administrator will answer them.

SPECIAL ENROLLMENT RIGHTS

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Applicant provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

Loss of Other Coverage

If You declined coverage under this Plan in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to Your exhaustion of the maximum COBRA period;

2. Due to Your involuntary loss of eligibility, for any reason;

Special Enrollment Rights - continued

3. Ends Employer contributions towards the cost of the other coverage.

4. The amount of Plan contribution (i.e., premium) that You are required to pay for coverage under this Plan decreases by at least 10% of the total premium in any 12-month period.

Then a special enrollment event has occurred. At that time, an Employee or Dependent may enroll in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependent may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;

2. When a Dependent has a loss of coverage, that Dependent, the Employee and other Dependents may enroll. The Employee and the other Dependents do not have to have had a loss of coverage at that time to enroll. Other Dependents that did not have a loss of coverage will be considered Late Applicants.

You must enroll in this Plan within 30 days of the date of a loss of other coverage to be a timely entrant to the Plan. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this Plan will not be effective until such proof is provided. Coverage under this Plan will be effective on the day after coverage under the other group plan ends.

You will be eligible to enroll in the Plan if Your completed enrollment form is received by the Plan Administrator within 30 days of the date that other coverage was lost. Coverage will be effective on the first day of the month after the Plan Administrator receives Your completed enrollment form.

If You apply more than 30 days after the date the other coverage ends, You will be a Late Applicant under this Plan and will be ineligible to enroll due to Late Enrollment.

Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage may also be enrolled at this time. Any other Dependents that were not previously covered under the Plan will be considered Late Applicants.

You must enroll in this Plan within 30 days of the date of marriage to be a timely entrant to the Plan. Coverage under the Plan will be effective on the day of Your marriage.

If You apply more than 30 days after the date of Your marriage, it will be considered late enrollment under this Plan and will be ineligible to enroll due to Late Enrollment.

Birth, Adoption or Placement for Adoption

If You experience the birth of a Dependent child, or the adoption or placement for adoption of a Dependent child, a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse, newborn or adopted child may also be enrolled at this time, as well as any other Dependents that were not covered under the Plan may also be enrolled at this time.

You must enroll in this Plan within 30 days (one year for a newborn or adopted child) of the date of birth, adoption or placement to be a timely entrant to the Plan. Coverage under the Plan will be effective on the date of such an event.

Special Enrollment Rights – continued

If You apply more than 30 days (one year for a newborn or adopted child) after the date of such an event, it will be considered late enrollment under this Plan and will be ineligible to enroll due to Late Enrollment.

Limitations

This Special Enrollment Rights provision does not apply to You or Your Dependents if:

1. You are on an unpaid Leave of Absence (unless You have continued Your coverage on this Plan under Your legal rights to coverage continuation (e.g. COBRA) or You are on leave under the Family and Medical Leave Act); or

2. You are covered under the Retiree Coverage provision of this Plan, if offered.

MEDICAID/STATE CHILD HEALTH INSURANCE PLAN

If You and/or Your Dependents were covered under a Medicaid plan or State child health insurance plan and Your coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health insurance plan coverage ends.

You must request coverage under this Plan within 60 days after the date of termination of such coverage. Coverage under this Plan will be effective on the date the other coverage ends.

If You apply for coverage more than 60 days after the date the Medicaid or State child health insurance plan coverage ends, You will be considered a Late Applicant under this Plan.

Premium Assistance

Current Employees and their eligible Dependents may be eligible for a special enrollment event if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or State child health insurance plan, for premium assistance with respect to coverage under this Plan. You must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance. If You apply for coverage more than 60 days after this date, You will be considered a late Applicant under the Plan.

SPOUSAL TRANSFER PROVISION

If both spouses are Employees and eligible for coverage under this Plan and Your spouse previously waived coverage as an Employee in favor of coverage as Your Dependent, this Plan may permit Your spouse to take coverage as an Employee under the Plan and to enroll You and any other eligible Dependents as Dependents of Your spouse when:

1. You and Your spouse decide to transfer coverage under the Plan from one spouse to the other;

2. Your spouse decides to take coverage as an Employee for any reason; or

3. You terminate Your coverage under the Plan for any reason.

Your spouse must elect coverage under this Plan within 30 days of the date Your coverage ends to be a timely enrollment. Your spouse's coverage under this Plan will be effective on the day Your coverage ends. If Your spouse applies more than 30 days after the date Your coverage ends, You will be Late Applicants under the Plan.

Spousal Transfer Provision – continued

When two spouses are employed at Marathon County, the Employee who is enrolled as the Covered Employee (e.g. Plan subscriber) will have premium deductions apply. The County will annually determine which County department is responsible for paying the Employer share of the family premium, based on departmental revenue sources and employee circumstances. This may require completion of a new enrollment form to change the Covered Employee (e.g. the Plan subscriber).

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all Employees and Dependents. Any change in coverage will be effective on the date of change for all Employees and Dependents.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

If You are not Actively at Work, You may be allowed to continue Your coverage under this Plan. Coverage continuation will apply as outlined in Your Employer's employment handbook. You may be required to continue paying Plan contributions (if any) during this continuation of coverage. The Plan must remain in effect to apply this provision.

REHIRED EMPLOYEES AND REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;

2. For any benefit, the date removal of the benefit from the Plan by Amendment is effective;

3. The end of the period for which any required Employee or Employer contribution was due and not paid;

4. The date You enter the full-time military, naval or air service of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

5. The last day of the month in which You cease to be eligible according to the eligibility requirements of Your Employer;

Termination of Coverage – continued

6. For all Employees, the last day of the month in which Your termination of employment with Your Employer occurs or, if earlier, the last day of the month in which You are no longer Actively at Work as defined in this Plan. (**Exception**: Refer to the "Special Provisions For Not Being Actively at Work" provision stated earlier in this section of the Plan.)

7. For Employees, the last day of the month in which Your retirement occurs;

8. For a Dependent, the date the Employee's coverage terminates;

9. For a Dependent, the date You enter the military forces of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

10. For a Dependent, the last day of the month in which the Dependent no longer meets this Plan's definition of a Dependent;

11. For a Dependent child, the last day of the month in which the child reaches age 26;

12. For a step-child, the date of final divorce between You and the biological parent, or the end of the month the biological parent dies, or the end of the month in which the child reaches the limiting age;

13. For an Employee's spouse, the date of entry of a judgement of divorce or annulment of the marriage;

14. The date You request termination of coverage to be effective for Yourself and/or Your Dependents, if allowed by your group's Section 125 plan;

15. For an Employee, the date you die; or

16. If an Employee dies while covered under this Plan, that Employee's covered Dependent Spouse and covered Dependent children may be allowed to stay on this Plan until the last day of the month in which the Employee dies. Other provisions may apply if listed elsewhere in this Plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect;

2. It is attributable to non-payment of premiums or contributions; or

3. It is initiated by You or Your personal representative.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

The Plan cannot terminate Your coverage due to age or Medicare status. An active Employee who is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this Plan, in which case Medicare benefits would be secondary to this Plan, or

2. End coverage under this Plan, in which case Medicare would be the only coverage available to You.

An active Employee's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.

Contact Your Employer for further information.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to Employers with 50 or more Employees. It requires that coverage under this Plan be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the Employee as it would have been had FMLA leave not been taken.

If this Plan is established while You are on FMLA, Your coverage will be effective on the same date it would have been had You not taken leave. If the Plan is amended while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken leave.

EMPLOYEE ELIGIBILITY

An Employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The Employee has been employed with the Employer for a total of at least 12 months;

2. The Employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and

3. The Employee is employed at a worksite that employs at least 50 Employees.

TYPES OF LEAVE

Coverage under this Plan can be continued during a period of FMLA leave. The Employee must continue to pay the Employee portion of the Plan contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the Employer, for:

1. The birth of the Employee's child;

2. The placement of a child with the Employee for adoption. The placement of a child with the Employee for foster care;

3. The Employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;

4. The Employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or

5. Any qualifying necessity that results from the Employee's spouse, son, daughter or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the Employer, to care for a member of the armed forces that is the Employee's spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

FMLA - continued

Maximum Leave Period

The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the Employee and the Employee's spouse are both employed by the Employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;

2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or

3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period

If the Employee decides not to return to work, coverage under the Plan may end at that time.

If the Plan contribution is not paid within 30 days of its due date, coverage under the Plan may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an Employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions

The Employer has the right to recover the portion of Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave. If the Employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work. Reinstatement will apply whether coverage under the Plan was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived.

DEFINITIONS

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

Serious Health Condition is any Sickness, Injury, impairment or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;

2. Continuing treatment by a Qualified Practitioner, including any period of incapacity:

    a. for more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or a Qualified Practitioner is consulted at least once and a continuing treatment program is provided;
    b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
    c. due to a chronic condition (i.e. a condition which requires periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
    d. which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective;
    e. to receive multiple treatments from a Qualified Practitioner for restorative surgery due to Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

    Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is Your lawful husband or wife.

Son or Daughter is Your natural blood related child, adopted child, step-child, foster child, a child placed in Your legal custody or a child for which You are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or

2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is Your natural blood related parent or someone who has acted as Your parent in place of Your natural blood related parent.

NOTE: To the extent that State or local law requires an Employer to provide greater leave rights than those stated above, this Plan will provide that greater right. For complete information regarding Your rights under the FMLA, contact Your Employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that the Employer provide a cumulative total of five years, and in certain instances more than five years, of military leave during an Employee's employment with the Employer.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that the Employer continue to provide coverage under this Plan, during a military leave that is covered by the Act, for You and Your Dependents. Coverage provided must be identical to coverage provided under the Employer's Plan to similarly situated, active Employees and Dependents. This means that if the coverage for similarly situated, active Employees and Dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the Employee contribution required for active Employees;

2. For military leaves of 31 days or more, up to 102% of the full contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages. Short and long term disability and life benefits are not subject to this provision.

For an Employer subject to COBRA, continued coverage provided under this Act will reduce any continuation provided under COBRA.

Maximum Period of Coverage during Military Leave

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

1. The date You fail to return to Employment with the Employer following completion of Your military leave. Employees must return to employment within:

    a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b. 14 days of completing military service, for leaves of 31 to 180 days,
    c. 90 days of completing military service, for leaves of more than 180 days; or

2. 24 months from the date Your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day of completing Your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

2. 14 days of completing Your military service, for leaves of 31 to 180 days;

3. 90 days of completing Your military service, for leaves of more than 180 days.

USERRA - continued

If, due to a Sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived as if You had been continually covered under the Plan from Your original effective date.

This waiver of limitations does not provide coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veterans Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to Employers that have 20 or more employees. The law requires these Employers to offer covered individuals continuation coverage (COBRA) under the Plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The Employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active Employees under the Plan. This means that when coverage is changed for similar active Employees it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work; or

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part.

Spouse Rights to COBRA

The spouse of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, or divorce; or

5. The Employee becoming entitled to Medicare.

Dependent Child Rights to COBRA

The Dependent child of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

COBRA - continued

4. The end of the Employee's marriage. The marriage must end due to dissolution, annulment, or divorce;

5. The Employee becoming entitled to Medicare; or

6. The child ceasing to be considered a Dependent child as defined in this Plan.

Electing COBRA

Each person covered by this Plan has an independent right to elect COBRA for himself or herself. A Covered Employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the Employee's Dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the Employee during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, You have a right to elect COBRA. You also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the Employer files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, You must inform the Plan Administrator within 60 days of: a divorce; annulment; or dissolution of marriage. You must also inform the Plan Administrator within 60 days of a child no longer meeting the Plan's definition of Dependent. Notice must be provided within the 60-calendar day period that begins on the latest of:

1. The date of the qualifying event; or
2. The date on which there is a Loss of Coverage (or would be a loss of coverage) due to the original qualifying event; or
3. The date on which the qualified beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Employer must notify the Plan Administrator of: the Employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The Employer must also notify the Plan Administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the Plan Administrator will notify You that You have the right to elect COBRA. If the Employer and Plan Administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law You must elect COBRA in writing or via the online portal, if available, within 60 days from the later of: the date You would lose coverage or cost would increase due to the qualifying event; or the date notice of Your right to COBRA and the election form are sent. If online election is available, You will receive instructions for online election when Your election notice is provided.

COBRA - continued

The Plan Administrator must provide You with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. All other payments are due on a monthly basis, subject to a 30 day grace period.

If You elect COBRA within the 60 day period, COBRA will be effective on the date that You would lose coverage. If You do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the Plan will terminate.

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The Plan may add a 2% administration charge to that cost. The Plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

The cost of continuation coverage is subject to change at least once per year. The timing of the one-year period is set by the Plan Administrator.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the Employer maintain COBRA for up to:

1. 18 months, if due to the Employee's termination of employment. Termination must be for reasons other than gross misconduct on the Employee's part;

2. 18 months, if due to the Employee's reduction in work hours;

3. 36 months, if due to the death of the Employee;

4. 36 months, if due to the end of the Employee's marriage. The marriage must end due to dissolution, annulment, or divorce;

5. 36 months, if due to the Employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the Employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to Your ceasing to be a Dependent child as defined in the Plan; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered Dependent may elect COBRA for an additional 36 months from that date.

If You or a Dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if You or a Dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the Plan Administrator within 60 days of the later of:

1. The date of the Social Security Act disability determination;

COBRA – continued

2. The date that the qualifying event occurs;

3. The date the qualified beneficiary loses (or would lose) coverage due to the original qualifying event or the date that Plan coverage was lost due to the original qualifying event; or
4. The date on which the qualified beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, You will not be eligible for the extended period. If it is determined that You are no longer disabled, You must notify the Plan Administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the Employee's death; the Employee's divorce; a child no longer meeting the definition of Dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active Employee or Dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the Plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The Employer no longer provides a group benefit plan to any of its Employees;

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to You. You will have 30 days from the date of notice to make the additional payment;

3. You obtain another group plan after the date You elect COBRA;

4. You become entitled to Medicare after the date You elect COBRA;

5. There has been a final determination that You are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

COBRA - continued

Procedures for Providing Notice to the Plan

In order to maintain Your rights under COBRA, You are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if You provide written notice to the Plan Administrator that includes:

1. The Employee's name and participant number;

2. The name of the individual(s) to whom the notice applies;

3. The reason for which notice is being provided; and

4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan or sent via the online portal, if available. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The Plan Administrator will answer any questions You may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to Your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect Your rights under COBRA, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status; address; or other insurance coverage. When providing any notice to the Plan, a copy should be maintained for Your own records.

SPECIAL NOTICE

(Read This If Thinking Of Declining COBRA Continuation Coverage)

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through a special enrollment event. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the qualified beneficiary will lose his or her Special Enrollment Rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the qualified beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or exchange. After COBRA continuation coverage is exhausted, the qualified beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange in accordance with his or her HIPAA special enrollment rights.

INDIVIDUAL MEDICAL CONVERSION PRIVILEGE

An individual conversion plan is available from the Trust. The Plan Administrator will, during the 180-day period before the applicable end of continuation coverage, offer a Covered Person who is covered until the end of the maximum period of continuation coverage the option of enrollment under a Conversion health plan.

Benefits provided under Conversion will differ from those of this Plan.

SECTION 4 GENERAL PLAN INFORMATION

COORDINATION OF BENEFITS

Benefits Subject to This Provision

Benefits described in this Plan are coordinated with benefits provided by other plans which also cover You. This is to prevent the problem of over-insurance and a resulting increase in the cost of coverage. This coordination of benefits provision applies whether or not You file a claim under any other plan You may be covered under.

If both the Employee and a Dependent are eligible for Employee coverage under this Plan, each Covered Expense is payable only once and each Covered Person is covered only once. (When the Employer employs both an Employee and the Employee's Covered Dependents, only one plan is permitted per Covered Family. Two individual plans or double coverage is not allowed).

Effect on Benefits

Benefits will be reduced under certain circumstances when You are covered both under this Plan, as described, and any other plan, as defined below, which provides similar benefits. Total reimbursement from all plans will not exceed 100% of the total Covered Expenses under this Plan.

Definitions

For this Coordination of Benefits provision only, a plan is any coverage which covers medical, dental or vision expenses and provides benefits or services by:

1. Group or franchise insurance coverage, whether insured or self-funded;

2. Hospital or medical service organizations on a group basis and other group pre-payment plans;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage sponsored or provided by or through an educational institution;

5. Any governmental program or a program mandated by state statute;

6. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group type contracts not available to the general public obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket or in something else.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Covered Expenses. These plans are called secondary plans.

Coordination of Benefits - continued

When a plan provides benefits in the form of services rather than cash payments, the Usual and Customary charge, the Negotiated Rate, or the fee schedule value of each service provided will be deemed to be both a Covered Expense and a benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination

A plan will be considered the primary plan and pay benefits first if:

1. The plan has no coordination of benefits provision.

2. The plan covers the person as an Employee.

3. When a Dependent child is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering a parent for the longest period of time will pay benefits first. If a plan other than this Plan does not use the birthday rule and uses the gender rule instead, then the gender rule will be followed.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents, No. 3 (see above) will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:

   a. the plan of a parent who has primary physical placement will be primary,
   b. the plan of a step-parent that has primary physical placement will pay benefits next,
   c. the plan of a parent who does not have primary physical placement will pay benefits next, and
   d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

   If one parent has been assigned financial responsibility for the medical expenses of the child, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. In the case of a married Dependent child, if the individual is covered under a spouse's plan and also under their parent's plan, the primary plan is the plan that has covered the person for the longer period of time. 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 plan of the parent or spouse whose birthday falls earlier in the Calendar Year is the primary plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the primary plan.

7. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:

   a. the plan of a parent who has primary physical placement will pay the benefits first,
   b. the plan of a parent who does not have primary physical placement will pay benefits next,
   c. the plan of a grandparent whose child has primary physical placement will pay benefits next,
   d. the plan of a grandparent whose child does not have primary physical placement will pay benefits next.

Coordination of Benefits - continued

Subject to the order of benefit determination stated above, if both grandparents in a household are providing coverage for a grandchild, the plan of the grandparent whose birthday (month and day) occurs first in the Calendar Year will pay before the plan of the other grandparent. If both grandparents in a household have the same birthday, the plan covering a grandparent for the longest period of time will pay benefits first.

If the primary plan is not established by the above rules, the plan that has covered the grandparent or parent for the longest period will be primary.

8. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the Dependent of such a person will pay benefits after the plan covering such persons as an active Employee or the Dependent of an active Employee. **There are two exceptions to this**: a) If a plan other than this Plan does not include a provision similar to this one and, if as a result, the plans do not agree on the order of benefits, this rule will be ignored, and b) If a Dependent is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule.

9. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active Employee or the Dependent of an active Employee.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this Plan does not include provision No. 3, then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

If a service is covered under a medical plan and a dental plan, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare (if applicable to this Plan)

In all cases, coordination of benefits with Medicare will conform to Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan are subject to the allowable limiting charges, as set by Medicare, and will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal Statutes and Regulations.

When Medicare is the primary payer:

1. This Plan will pay 100% after Medicare, less any Medicare payments or discounts. When Medicare allows a service, the Plan will pay up to the 100% coordination of benefits (COB) amount for that service, after Medicare has paid its benefit for such service. Once Medicare has exhausted its benefit for a service, the Plan will continue to pay up to the active Plan maximum only if the active Plan has a better benefit than Medicare. If there is a service that is completely excluded from Medicare, the active Plan will be reviewed to see if there is a benefit for that service. If the service is a Covered Expense under the active Plan, the benefit for such service will be paid at 100%.

Coordination of Benefits - continued

2. The medical deductible, copays and coinsurance will not apply except for Rx drugs (if applicable) or unless otherwise indicated.

3. All services covered for active Employees will be covered for Medicare-primary individuals, even if Medicare does not cover the service.

4. All services that Medicare covers will be covered for Medicare-primary individuals, even if the service is not covered for an active Employee under this Plan.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an Employee, Dependent or other.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's medical benefit Plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this Plan.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this Plan, You agree to all of the following conditions. The payment of any claims by the Plan is an advancement of Plan assets. The Plan has first priority to receive repayment of those Plan assets out of any amount You recover. The Plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before You receive payment from that party. The Plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The Plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not You are made whole.

The Plan will not pay attorney fees without the express written consent of the Plan Administrator. The Plan will not pay any costs associated with any claim or lawsuit without the express written consent of the Plan Administrator.

If You are deceased, the rights and provisions of this section will apply equally to Your estate. If You are legally incapacitated the rights and provisions of this section will apply equally to Your legal guardian.

In consideration of the coverage provided by this Plan, when You file a claim You agree to all of the following conditions. You will sign any documents that the Plan considers necessary to enforce its recovery rights. You will do whatever is necessary to enable the Plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the Plan any rights You have for expenses the Plan paid on Your behalf. You will hold any settlement funds in trust, either in a separate bank account in Your name or in Your attorney's trust account, until all Plan assets are fully repaid or the Plan agrees to disbursement of the funds in writing, if You receive payment from any liable or responsible party and the Plan alleges that some or all of those funds are due and owed to the Plan. You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the Plan. It also includes any medical, dental or loss of time expense that may be payable by the Plan in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; You or Your Covered Dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the Plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of Your benefits under this Plan.

Right of Subrogation

If, after payments have been made under this Plan, You have a right to recover damages from a responsible or liable party, the Plan shall be subrogated to that right to recover. The Plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the Plan.

Recovery Rights - continued

Right of Reimbursement

If benefits are paid under this Plan and You recover from a responsible or liable party by settlement, judgment or otherwise, the Plan has a right to recover from You. Recovery will be in an amount equal to the amount of Plan assets paid on Your behalf. The Plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of Plan assets that are paid or payable for any health care expenses under the Plan.

Excess Coverage Provision

Benefits are not payable for a Sickness or Injury if there is any responsible or liable party providing coverage for health care expenses You incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the Plan may make payments on Your behalf for Covered Expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the Plan and will be considered an advancement of Plan assets to You.

This Plan does not provide benefits or may reduce benefits for any present or future Covered Expenses that You have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the Plan.

Workers' Compensation

This Plan excludes coverage for any Sickness or Injury that is eligible for benefits under Workers' Compensation. If benefits are paid by the Plan and You receive Workers' Compensation for the same incident, the Plan has the right to recover. That right is described in this section. The Plan reserves its right to exercise its recovery rights against You even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the Sickness or Injury was sustained in the course of or resulted from Your employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by You or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.

You must notify the Plan Administrator of any Workers' Compensation claim You make. You agree to reimburse the Plan as described above.

GENERAL PROVISIONS

The following provisions are to protect Your legal rights and the legal rights of the Plan.

ALTERNATE RECIPIENTS

If a court order requires a Covered Person to provide health care coverage for a Dependent child, coverage must be provided to the child. Coverage may not be subject to Plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of Dependents are also waived for that child. If a Covered Person does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an Employee under the Plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the Plan. They must be provided with a copy of the Plan's Summary Plan Description (SPD). Any payments made by the Plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

A court order will not entitle the child to any benefits or coverage not already offered by the Plan.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan's benefits may be amended by the Employer at any time. The Plan may be terminated by the Employer at any time. Any changes to the Plan will be communicated immediately by the Employer to the persons covered under the Plan.

If the Plan is terminated, the rights of the Covered Persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable.

ASSIGNMENT

Any assignment will only be applied to the extent that the provider of services will refund any erroneous payments. The Plan Administrator does not guarantee the legal validity or effect of any assignment.

CLERICAL ERROR

A clerical error by the Employer, the Plan Administrator or the Claims Administrator will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

CONFORMITY WITH APPLICABLE LAWS

If any provision of this Plan is contrary to any applicable law, that provision is amended to conform to such law and the rest of the Plan remains in effect.

CONTRIBUTIONS TO THE PLAN

The Plan is funded by contributions from the Employer and Covered Employees.

The Employer determines the amount of the Employee contribution, if any, and reserves the right to adjust or modify such contributions. All Employee contributions are on a non-discriminatory basis.

COOPERATION

You must cooperate with the Plan Administrator, Claims Administrator, and or any person designated by the Plan Administrator in connection with this Plan.

FAILURE TO ENFORCE PLAN PROVISIONS

No failure to enforce any provision of the Plan will affect the right, thereafter, to enforce such provision or affect the right to enforce any other provisions of the Plan.

FREE CHOICE OF PROVIDER

The Covered Person has a free choice of any legally licensed provider. The Plan will not interfere with the provider/patient relationship.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This Plan is not financed or administered by an insurance company and benefits are not guaranteed by a contract of insurance.

If You have any questions about Your rights under the Health Insurance Portability and Accountability Act of 1996, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S, Department of Labor, listed in Your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 2000 Constitution Avenue, N.W., Washington D.C. 20210.

LEGAL ACTIONS

You cannot bring an action to compel payment under the Plan until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the Plan has denied full payment of Your claim, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

PAYMENT OF CLAIMS

Any payment made in good faith will fully discharge the Plan to the extent of such payment. If benefit payments have been made under any other plan which should have been made under this Plan, the Plan Administrator may reimburse such plan. Any payments made in good faith will fully discharge the Plan's obligations to You to the extent of such payment.

Payment of Claims Provision - continued

Benefits will be paid directly to the provider of services, unless You direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of You or Your Covered Dependent, upon death, will be paid at the Plan Administrator's option to: Your estate; Your spouse; Your Dependent children; Your parents; or Your brothers and sisters.

PHYSICAL EXAMINATION

The Plan Administrator, at its own expense, has the right to have You examined as often as it deems reasonably necessary while a claim is pending.

PRIVACY OF PROTECTED HEALTH INFORMATION

1. **Plan Sponsor's Certification of Compliance**

   Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. **Purpose of Disclosure to Plan Sponsor**

   a. The Plan and any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of Wisconsin law and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Such disclosure will include disclosure for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in the Plan's Notice of Privacy Practices. Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.

   b. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.

   c. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

3. **Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information**

   a. The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.

   b. The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' Protected Health Information.

Privacy of Protected Health Information - continued

c. The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

d. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

e. The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524 and any applicable Wisconsin law.

f. The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526 and any applicable Wisconsin law.

g. The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528 and any applicable Wisconsin law.

h. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E ("Privacy of Individually Identifiable Health Information").

i. The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium, received from the Plan or any Business Associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information that cannot feasibly be return or destroyed to those purposes that make the return or destruction of the information feasible.

j. The Plan Sponsor will ensure that the required adequate separation, described in detail in paragraph 4, below, is established and maintained.

4. **Adequate Separation Between the Plan Sponsor and the Plan**

a. The following persons under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a Business Associate servicing the Plan:

Employees of Wisconsin Counties Association who hold the positions of Director of Insurance Services, Director of Administration and Finance, Insurance Services Administrator, Operations Manager, Executive Administrative Assistant, Administrative Assistant.

All employees of all entities with whom the Plan has entered into Business Associate Agreements to the extent those employees perform tasks for or on behalf of the Plan and/or the Plan Sponsor.

This list includes every employee or class or employees or other persons under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The employees or other persons above shall also be given access to Plan Participants' Protected Health Information for the purpose of rendering final claim appeal determinations.

b. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

c. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

5. **Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

a. The Plan may disclose Summary Health Information (SHI) to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information (SHI) for the purpose of:

1. Obtaining premium bids for the health coverage offered under the Plan; or

2. Modifying, amending or terminating the Plan.

Summary Health Information (SHI) includes aggregated claims history, claims expenses or types of claims experienced by enrollees in the Plan. Although this information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the SHI as belonging to a particular participant.

b. The Plan may disclose enrollment and disenrollment information to the Plan Sponsor.

PROOF OF LOSS

You must provide the Plan with written proof of Your claim. Proof should be provided within 90 days after the date the claim was incurred. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless You were legally incapacitated during the period, any claim received by the Plan more than 16 months after the date the claim was incurred will not be covered under the Plan.

If the Plan is terminated, written proof of any claims incurred prior to the termination must be given to the Plan within 12 months of its termination. Any claim received by the Plan more than 12 months after it is terminated will not be covered under the Plan.

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind and any attempt to accomplish these will be void. If the Plan Administrator finds that such an attempt has been made, the Plan Administrator, at its sole discretion, may terminate the interest of the Covered Person in the payments and apply the amount of the payment to or for the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan to the extent of the payment.

REPRESENTATIONS

All representations by a Covered Person are material and relied upon in providing coverage under the Plan.

RIGHT TO NECESSARY INFORMATION

The Claims Administrator has the right to decide which facts it needs to apply and coordinate these provisions with other plans. It may get needed facts from or give them to any other organization or person without consent of the insured, but only as needed to apply these provisions. Medical records remain confidential as provided by state law. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

SECURITY

The WCA Group Health Trust, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Trust certifies to the Plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Employer under this provision;

3. Report to the Plan any security incident that the Trust becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

TERMINATION OF THE PLAN

If the Plan is terminated, the rights of the Covered Persons to benefits are limited to claims incurred and payable by the Plan before the date of termination. Upon notice of termination, prescription drugs will only be dispersed up to a 30 day supply per prescription one month prior to the Plan's termination.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, Your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the Plan will notify You of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the Plan will give its decision on the claim. If You fail to provide the information requested by the Plan, the Plan will provide You with its decision on the claim within 48 hours of the end of the period that You were given to provide the information.

If You fail to follow the Plan procedure for a Pre-Service Claim, the Plan will notify You within 24 hours of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for You to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a Plan Amendment. This will not apply if the benefit is being stopped due to the termination of the Plan.

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, Your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-Urgent Care claim. The Plan may extend this period by 15 days if You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If You fail to follow the Plan procedure for a non-Urgent Care Pre-Service Claim, the Plan will notify You within five days of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

CLAIM APPEAL PROCEDURE

MEDICAL APPEALS

A two-level appeal process is available under this Plan, followed by the Federal External Review Program. The first level of appeal is to the Claims Administrator (UMR). If You disagree with the result of the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust).

FIRST LEVEL OF APPEAL

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the Claims Administrator, for a full and fair review of the claim by the Plan;
2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of Your appeal.

A request for a review must be filed with the Claims Administrator within 180 days after receipt of the claim denial. If Your request for review is not received within 180 days, Your right to appeal the claim denial is forfeited.

If Your request for review is received within 180 days, a full and fair review of the claim will be held by the Claims Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide You with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

After the review, the Plan's decision will be made to You in writing. It will include specific reasons for the decision as well as specific references to the Plan provisions on which the decision is based. You will be notified of the Plan's decision as follows:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter timeframe;

2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter timeframe; or

3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

SECOND LEVEL OF APPEAL

If You disagree with the Plan's decision on the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust) by using the procedures outlined below:

Request for Review
Upon completion of the first level of appeal, any participating Covered Employee or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim.

The written request must be submitted to the Claims Review Committee within **ninety (90) days** after receipt of the Plan's decision on the first level of appeal. The request shall be accompanied by any evidence and argument the participating Covered Employee or beneficiary wishes to present.

Send Your request to the WCA Claims Review Committee through UMR at the following address:

UMR, INC.
CLAIM APPEALS
PO BOX 30546
SALT LAKE CITY UT 84130

When requesting a review, You should state the reasons You believe the denial was improper and submit any additional information, material or comments which You consider appropriate.

Review
Upon timely receipt of a request for review, the Claims Review Committee will schedule a review of Your appeal. The Claims Review Committee ordinarily meets by telephone conference. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Claims Review Committee will provide that information to You free of charge and sufficiently in advance of the due date of the response to Your appeal. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide You with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be extended to allow You a reasonable opportunity to respond to the new or additional evidence.

Decision
You will be notified of the Claims Review Committee's decision as follows, affirming, modifying or setting aside the previous decision or action:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;

2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or

3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;

2. The exclusion for experimental or investigational services or unproven services;

3. Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;

4. Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);

5. Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
   a. Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
   b. Whether a claim for items and services was furnished by an Out-of-Network provider at an In-Network facility;
   c. Whether an individual gave informed consent to waive the protections under the No Surprises Act;
   d. Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
   e. Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by an Out-of-Network provider at an In-Network facility; or

6. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR, Inc., or Your Employer fail to respond to Your appeal within the timelines stated above.

You may request an independent review of the adverse benefit determination. Neither You nor UMR, Inc. or Your Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS – UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR, INC.
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Federal External Review Program - continued

Your written request should include:

1. Your specific request for an external review;

2. The Employee's name, address, and member ID number;

3. Your designated representative's name and address, when applicable;

4. The service that was denied; and

5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the adverse benefit determination. You, Your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a Covered Expense by the Plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or Your Employer. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;

2. All other documents relied upon by UMR, Inc. and/or Your Employer in making a decision on the case; and

3. All other information or evidence that You or Your physician has already submitted to UMR, Inc. or Your Employer.

If there is any information or evidence You or Your physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR, Inc. and/or Your Employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

Federal External Review Program - continued

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PRESCRIPTION DRUG APPEALS

All non-specialty appeals will be handled by CVS Caremark. All specialty appeals will be handled by National CooperativeRx.

Coverage review description
A Member has the right to request that a medication be covered or be covered at a higher benefit (e.g., a lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review.

How to request initial review
The prescriber or dispensing pharmacist may submit a request for an initial review via fax or in writing to the appropriate appeals processer.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review.

How a coverage review is processed
In order to make an initial determination for a clinical coverage review request, the patient or prescriber must submit specific information to the prior authorization processor for review. For an administrative coverage review request, the Member must submit information to support the request. The initial determination and notification to the Member and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request, but no later than:
Standard Pre-Service*	15 days
Standard Post-Service*	30 days
Urgent	72 hours

*If necessary, this period may be extended one-time for up to 15 days if the extension is necessary due to matters beyond the control of the Prescription Drug Plan and the Member is notified prior to the expiration of the initial review period. If an extension is necessary because the claimant failed to provide the necessary information needed to make a determination, the claimant will have 45 days from receipt of the notice within which to provide the needed information. The claim will be denied in full if the claimant fails to timely provide the information within 45 days.

Prescription Drug Appeals – continued

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied
When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the Member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

1. Name of patient
2. Member ID
3. Phone number
4. The drug name for which benefit coverage has been denied
5. Brief description of why the claimant disagrees with the initial adverse benefit determination
6. Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax directly to the appeals processor. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed
Appeals will be completed in accordance with business policies that are aligned with state or federal regulations as applicable. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff Member, or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request, but no later than:**
Standard Pre-Service	15 days
Standard Post-Service*	30 days
Urgent	72 hours

*If necessary, this period may be extended one-time for up to 30 days if the extension is necessary due to matters beyond the control of the Prescription Drug Plan and the Member is notified prior to the expiration of the initial review period and the Member agrees to the extension.

The decision made on an urgent appeal is final and binding. In an urgent care situation, there is only one level of appeal prior to an external review.

Prescription Drug Appeals – continued

How to request a level 2 appeal after a level 1 appeal has been denied
When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the Member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

1. Name of patient
2. Member ID
3. Phone number
4. The drug name for which benefit coverage has been denied
5. Brief description of why the claimant disagrees with the adverse benefit determination
6. Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

An urgent level 2 appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appeals processor. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed
Appeals will be completed in accordance with business policies that are aligned with state or federal regulations as applicable. Appeal decisions are made by a pharmacist, physician, panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request, but no later than:
Standard Pre-Service	15 days
Standard Post-Service	30 days

When and How to request an External Review
The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the appeals processor and the request must be received within 4 months of the date of the final Internal adverse benefit determination. If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.

How an External Review is processed
Standard External Review: The appeals processor will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization ("IRO") and the patient will be notified.

Prescription Drug Appeals – continued

If the request is eligible to be forwarded to an IRO, the request will be compiled and sent to the IRO within 5 business days of receipt. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the prescriber, and the appeals processor written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours of receipt of the request and will send the claimant written notice of its decision.

Non-Specialty Prescription Drug Appeals

Appeals should be sent in writing via fax or mail to:
PRESCRIPTION CLAIM APPEALS MC 109 CVS CAREMARK
PO BOX 52084
PHOENIX AZ 85072
Fax: 1-866-443-1172

Specialty Prescription Drug Appeals

Appeals should be sent in writing via fax or mail to:
NATIONAL COOPERATIVERX PRESCRIPTION CLAIM APPEALS
2418 CROSSROADS DRIVE SUITE 2600
MADISON WI 53718
Fax: 1-866-278-8190