

**SCHOOL DISTRICT OF MENOMONEE
FALLS
MENOMONEE FALLS WI**

**Health Booklet
Benefit Plan(s) 001, 002, 003, 004 – Post – 65 Retirees**

Revised 01-01-2018

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

Table of Contents

INTRODUCTION.....	1
PLAN INFORMATION	2
MEDICAL SCHEDULE OF BENEFITS	4
MEDICAL SCHEDULE OF BENEFITS	9
TRANSPLANT SCHEDULE OF BENEFITS	14
PRESCRIPTION SCHEDULE OF BENEFITS	15
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	16
ELIGIBILITY AND ENROLLMENT	18
SPECIAL ENROLLMENT PROVISION	19
TERMINATION	20
COBRA CONTINUATION OF COVERAGE.....	21
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994	27
PROVIDER NETWORK.....	28
COVERED MEDICAL BENEFITS	29
HOME HEALTH CARE BENEFITS.....	41
TRANSPLANT BENEFITS	42
PRESCRIPTION DRUG BENEFITS.....	45
HEARING AID BENEFITS.....	51
MENTAL HEALTH BENEFITS.....	52
SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS	54
CARE MANAGEMENT	55
COORDINATION OF BENEFITS	59
RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET	63
GENERAL EXCLUSIONS	66
CLAIMS AND APPEAL PROCEDURES	72
FRAUD.....	81
OTHER FEDERAL PROVISIONS	82

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION	84
PLAN AMENDMENT AND TERMINATION INFORMATION	88
GLOSSARY OF TERMS	89

SCHOOL DISTRICT OF MENOMONEE FALLS

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the SCHOOL DISTRICT OF MENOMONEE FALLS Health Benefit Plan (the "Plan"). You are a valued Employee of SCHOOL DISTRICT OF MENOMONEE FALLS, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

SCHOOL DISTRICT OF MENOMONEE FALLS is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Express Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

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. Therefore, it will be referred to as both the SPD and the Plan document.

This document became effective on January 1, 2017.

PLAN INFORMATION

Plan Name	SCHOOL DISTRICT OF MENOMONEE FALLS HEALTH PLAN
Name And Address Of Employer	SCHOOL DISTRICT OF MENOMONEE FALLS W156 N8480 PILGRAM RD MENOMONEE FALLS WI 53051
Name, Address, And Phone Number Of Plan Administrator	SCHOOL DISTRICT OF MENOMONEE FALLS W156 N8480 PILGRAM RD MENOMONEE FALLS WI 53051 262-255-8440
Named Fiduciary	SCHOOL DISTRICT OF MENOMONEE FALLS
Employer Identification Number Assigned By The IRS	39-6003374
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	SCHOOL DISTRICT OF MENOMONEE FALLS W156 N8480 PILGRAM RD MENOMONEE FALLS WI 53051 Service of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	July 1 through June 30
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary, capricious, or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and, further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

**MEDICAL SCHEDULE OF BENEFITS
POST 65 RETIREES**

Benefit Plan(s) 001, 002

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

	TRADITIONAL
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: <ul style="list-style-type: none"> • Per Person • Per Family <p><i>Note: If Family Coverage is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.</i></p>	 \$2,000 \$4,000
Plan Participation Rate, Unless Otherwise Stated Below: <ul style="list-style-type: none"> • Paid By Plan After Satisfaction Of Deductible 	100%
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: <ul style="list-style-type: none"> • Per Person • Per Family <ul style="list-style-type: none"> – Individual “Embedded” Out-Of-Pocket Maximum <p><i>Note: If Family Coverage is Elected, The Full Family Out-Of-Pocket Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.</i></p>	 \$4,000 \$8,000 \$6,550
Ambulance Transportation: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Breast Pumps: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: <p>For Men:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>For Women:</p> <ul style="list-style-type: none"> • Paid By Plan 	 100% 100% (Deductible Waived)

	TRADITIONAL
Durable Medical Equipment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Emergency Services / Treatment: <p>Urgent Care:</p> <ul style="list-style-type: none"> • Co-pay Per Visit \$75 • Paid By Plan After Deductible 100% <p>Emergency Room Only:</p> <ul style="list-style-type: none"> • Co-pay Per Visit \$250 (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan After Deductible 100% <p>Emergency Physicians Only:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: <ul style="list-style-type: none"> • Maximum Days Per Calendar Year 60 Days • Paid By Plan After Deductible 100% 	
Hearing Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p>Hearing Aids: To Age 18</p> <ul style="list-style-type: none"> • Maximum Benefit Every 3 Years 1 Hearing Aid Per Ear • Paid By Plan After Deductible 100% <p>Implantable Hearing Devices:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Home Health Care Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p><i>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours of Home Health Care Services.</i></p>	
Hospice Care Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Hospital Services: <p>Pre-Admission Testing:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p>Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p>Outpatient Services / Outpatient Physician Charges:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p>Outpatient Imaging Charges:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	

	TRADITIONAL
Outpatient Lab And X-Ray Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Manipulations: <ul style="list-style-type: none"> • Paid By Plan After Deductible <p><i>Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.</i></p>	100%
Maternity: <p>Routine Prenatal Services:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Non-Routine Prenatal Services, Delivery, And Postnatal Care:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p> <p>100%</p>
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: <p>This Section Does Not Apply To:</p> <ul style="list-style-type: none"> ➤ Preventive / Routine Services ➤ Manipulation Services Billed By Any Qualifying Provider ➤ Dental Services Billed By Any Qualifying Provider ➤ Therapy Services Billed By Any Qualifying Provider ➤ Any Services Billed From An Outpatient Hospital Facility <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Physician Office Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: <p>Preventive / Routine Physical Exams At Appropriate Ages:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Immunizations:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100% (Deductible Waived)</p> <p>100% (Deductible Waived)</p> <p>100% (Deductible Waived)</p>

	TRADITIONAL
<p>Preventive / Routine Mammograms And Breast Exams:</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan <p>Note: 3D Mammograms Are Covered.</p>	<p>1 Exam 100% (Deductible Waived)</p>
<p>Preventive / Routine Pelvic Exams And Pap Tests:</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	<p>1 Exam 100% (Deductible Waived)</p>
<p>Preventive / Routine PSA Test And Prostate Exams:</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	<p>1 Exam 100% (Deductible Waived)</p>
<p>Preventive / Routine Screenings / Services At Appropriate Ages And Gender:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100% (Deductible Waived)</p>
<p>Preventive / Routine Autism Screening: From Age 0 To 21</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100% (Deductible Waived)</p>
<p>Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	<p>1 Exam 100% (Deductible Waived)</p>
<p>Preventive / Routine Hearing Exams:</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible 	<p>1 Exam 100%</p>
<p>Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100% (Deductible Waived)</p>
<p>Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100% (Deductible Waived)</p>

	TRADITIONAL
<p>In Addition, The Following Preventive / Routine Services Are Covered For Women:</p> <ul style="list-style-type: none"> ➤ Treatment For Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-Deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies, And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* <ul style="list-style-type: none"> • Paid By Plan <p>*These Services May Also Apply To Men.</p>	<p>100% (Deductible Waived)</p>
<p>Sterilizations:</p> <p>For Men:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>For Women:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100%</p> <p>100% (Deductible Waived)</p>
<p>Temporomandibular Joint Disorder Benefits:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100%</p>
<p>Therapy Services:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>Note: Medical Necessity Will Be Reviewed After 25 Visits.</p>	<p>100%</p>
<p>Wigs (Cranial Protheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	<p>1 Wig (Cranial Protheses), Toupee, Or Hairpiece Up To \$250 100%</p>
<p>All Other Covered Expenses:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100%</p>

**MEDICAL SCHEDULE OF BENEFITS
POST 65 RETIREES**

Benefit Plan(s) 003, 004

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

	TRADITIONAL
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: <ul style="list-style-type: none"> • Per Person • Per Family <p><i>Note: If Family Coverage is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.</i></p>	 \$1,500 \$3,000
Plan Participation Rate, Unless Otherwise Stated Below: <ul style="list-style-type: none"> • Paid By Plan After Satisfaction Of Deductible 	100%
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: <ul style="list-style-type: none"> • Per Person • Per Family <p><i>Note: If Family Coverage is Elected, The Full Family Out-Of-Pocket Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.</i></p>	 \$2,000 \$4,000
Ambulance Transportation: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Breast Pumps: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: <p>For Men:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>For Women:</p> <ul style="list-style-type: none"> • Paid By Plan 	 100% 100% (Deductible Waived)
Durable Medical Equipment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%

	TRADITIONAL
Emergency Services / Treatment: Urgent Care: <ul style="list-style-type: none"> • Co-pay Per Visit After Deductible \$35 • Paid By Plan After Deductible 100% <p>Note: Co-pay Applies After Satisfaction Of The Deductible.</p> Emergency Room Only: <ul style="list-style-type: none"> • Co-pay Per Visit After Deductible \$100 (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan After Deductible 100% <p>Note: Co-pay Applies After Satisfaction Of The Deductible.</p> Emergency Physicians Only: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: <ul style="list-style-type: none"> • Maximum Days Per Calendar Year 60 Days • Paid By Plan After Deductible 100% 	
Hearing Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% Hearing Aids: To Age 18 <ul style="list-style-type: none"> • Maximum Benefit Every 3 Years 1 Hearing Aid Per Ear • Paid By Plan After Deductible 100% Implantable Hearing Devices: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Home Health Care Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% <p>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours of Home Health Care Services.</p>	
Hospice Care Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	
Hospital Services: Pre-Admission Testing: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 100% 	

	TRADITIONAL
Outpatient Imaging Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Outpatient Lab And X-Ray Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Manipulations: <ul style="list-style-type: none"> • Paid By Plan After Deductible <p><i>Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.</i></p>	100%
Maternity: <p>Routine Prenatal Services:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Non-Routine Prenatal Services, Delivery, And Postnatal Care:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: <p>This Section Does Not Apply To:</p> <ul style="list-style-type: none"> ➤ Preventive / Routine Services ➤ Manipulation Services Billed By Any Qualifying Provider ➤ Dental Services Billed By Any Qualifying Provider ➤ Therapy Services Billed By Any Qualifying Provider ➤ Any Services Billed From An Outpatient Hospital Facility <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Physician Office Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: <p>Preventive / Routine Physical Exams At Appropriate Ages:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Immunizations:</p> <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)

	TRADITIONAL
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 100% (Deductible Waived)
Note: 3D Mammograms Are Covered.	
Preventive / Routine Pelvic Exams And Pap Tests: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Preventive / Routine Autism Screening: From Age 0 To 21 <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 100% (Deductible Waived)
Preventive / Routine Hearing Exams: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible 	1 Exam 100%
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)

	TRADITIONAL
<p>In Addition, The Following Preventive / Routine Services Are Covered For Women:</p> <ul style="list-style-type: none"> ➤ Treatment For Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-Deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies, And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* <ul style="list-style-type: none"> • Paid By Plan <p>*These Services May Also Apply To Men.</p>	<p>100% (Deductible Waived)</p>
<p>Sterilizations:</p> <p>For Men:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>For Women:</p> <ul style="list-style-type: none"> • Paid By Plan 	<p>100%</p> <p>100% (Deductible Waived)</p>
<p>Temporomandibular Joint Disorder Benefits:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100%</p>
<p>Therapy Services:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>Note: Medical Necessity Will Be Reviewed After 25 Visits.</p>	<p>100%</p>
<p>Wigs (Cranial Protheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	<p>1 Wig (Cranial Protheses), Toupee, Or Hairpiece Up To \$250 100%</p>
<p>All Other Covered Expenses:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100%</p>

**TRANSPLANT SCHEDULE OF BENEFITS
POST 65 RETIREES**

Benefit Plan(s) 001, 002, 003, 004

Transplant Services At A Designated Transplant Facility:	
Transplant Services: <ul style="list-style-type: none">• Paid By Plan After Deductible	100%
Travel And Housing: <ul style="list-style-type: none">• Maximum Benefit Per Transplant• Paid By Plan	\$10,000 100% (Deductible Waived)
Travel And Housing At Designated Transplant Facility At Contract Effective Date / Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

**PRESCRIPTION SCHEDULE OF BENEFITS
ADMINISTERED BY EXPRESS SCRIPTS**

Your Prescription Drug Co-pays Once Your Annual Medical And Pharmacy Deductible Is Met:

	Participating Retail Pharmacies Up To A 30-Day Supply	Walgreens Smart 90 Program Up To A 90-Day Supply At Walgreens	Express Scripts Pharmacy Mail-Order Service Up To A 90-Day Supply
Generic Drugs (Tier 1)	\$10	\$20	\$20
Brand-Name Drugs (Preferred-Tier 2)	\$25	\$50	\$50
Brand-Name Drugs (Non-Preferred-Tier 3)	\$50	\$100	\$100

Specialty medication Co-pays will follow the same tier level as standard medications but these must be purchased through the Accredo Specialty Pharmacy (www.Accredo.com) or by calling an Accredo Intake Care Representative at 1-888-608-9010.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person pays each time certain services are received. The Co-pay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to family deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Plan Participation amounts for Prescription products.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person’s claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

The Covered Person’s ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan’s Deductible.

**ELIGIBILITY AND ENROLLMENT
ALL RETIREES**

RETIREES

Retiree coverage as determined by Your employer. Please see Your employer for more details.

SPECIAL ENROLLMENT PROVISION

Note: Retirees (and their Dependents) who decline coverage under this Plan when it is initially offered are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not Covered Persons will not be eligible to enroll upon acquisition of new Dependents.

LOSS OF HEALTH COVERAGE

If Your eligible Dependents lose other health coverage, are otherwise eligible for coverage under this Plan, and did not enroll when first eligible because they had other health coverage, they may enroll for health coverage under this Plan if the following conditions are met:

- Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was first offered; and
- Your Dependents stated in writing that they declined coverage due to coverage under another group health plan or health insurance policy; and
- The coverage under another group health plan or health insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage was offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

If a person becomes an eligible Dependent through marriage, birth, adoption, or Placement for Adoption, the newly acquired Dependent who is not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Retiree must apply for coverage within 31 days of the marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the date of the marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of loss of coverage, on the date following loss of coverage.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

A person's coverage under this Plan will end on the earliest of:

- The date this Plan is terminated; or
- The date coverage for the former employee's benefit class is terminated; or
- The date You cancel coverage or fail to pay premiums as required. Coverage may be dropped at any time. If You choose to discontinue coverage, You permanently give up Your right to future coverage under this Plan for You and Your Dependents, unless otherwise eligible under the Annual Open Enrollment section; or
- The date You or Your Dependent submits a false claim or commit any fraudulent act related to this Plan or any other group plan; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section, unless the Child qualifies for extended Dependent coverage; or
- If Your Dependent Child qualifies for extended Dependent coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The date the former employee dies.

COBRA CONTINUATION OF COVERAGE

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your covered Dependents, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they may otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of this COBRA election.

DEFINITIONS

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, a partial Loss of Coverage, an increase in Retiree cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

Qualified Beneficiary means a person covered by this Plan immediately before a Qualifying Event. A Qualified Beneficiary may be a former employee, the legal spouse of a former employee, or the Dependent Child of a former employee. The retired employee is a Qualified Beneficiary if coverage is lost due to bankruptcy of the employer. A Dependent Child also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered retired employee.
- Divorce or legal separation of the covered retired employee from the retired employee's spouse. (Also, if a retired employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation, and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.
- Employer bankruptcy. Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding is filed with respect to this employer, and that bankruptcy results in the Loss of Coverage of any retired employee covered under this Plan, then the retired employee is a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Plan apply to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered former employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the former employee and spouse, or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, whether to Your former employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number;
- The group number and the name of the former employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

Send all notices or other information required by this Summary Plan Description in writing to:

**UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or to the COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER'S OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The former employer will give notice to the COBRA Administrator when coverage terminates due to the death of the former employee, the former employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both) or termination of coverage due to the former employer's bankruptcy. The former employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

QUALIFIED BENEFICIARY'S OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the former employee and a spouse or a Dependent Child ceasing to be eligible for coverage under the Plan. The covered former employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- 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 Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of the Qualifying Event from the former employer, the covered former employee, or the Qualified Beneficiary.

IMPORTANT: The group health plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the Qualified Beneficiary fails to provide this notice to the Plan Administrator within the allowable time periods stated above.

APPLYING FOR CONTINUATION COVERAGE UNDER COBRA

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 days after the later of:

- The date Your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an Election Notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, the Qualified Beneficiary's group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, coverage under this Plan will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the COBRA election material and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the former employer and former employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once per year.

If Your employer offers Annual Open Enrollment opportunities for former employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him or her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S OBLIGATIONS WHILE ON COBRA CONTINUATION

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any of one the following events occurs:

- The Qualified Beneficiary's marital status changes. Refer to the Special Enrollment Provision section of this Plan for additional information regarding special enrollment rights.
- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.
- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

The maximum amount of time that covered Dependents may have COBRA continuation coverage is 36 months if coverage is lost due to the retired employee's death, due to divorce or legal separation, or due to a Dependent Child's loss of eligibility as a Dependent as defined in this document.

If, however, bankruptcy of the former employer is the Qualifying Event that causes Loss of Coverage, Qualified Beneficiaries may elect COBRA coverage for the following maximum period:

- The covered retired employee may continue COBRA coverage for the rest of his or her life.
- COBRA coverage for a covered spouse or surviving spouse or for a Dependent Child of the retired covered employee ends on the earlier of (1) the date the Qualified Beneficiary dies; or (2) the date that is 36 months after the death of the retired covered employee.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

Continuation coverage under COBRA may terminate before the end of the above maximum coverage periods for any of the following reasons:

- This former employer ceases to maintain a group health plan for any employees. (Note that if the former employer terminates the group health plan under which You are covered, but still maintains another group health plan for other, similarly situated employees, You will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions for the beneficiary.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment Provision section for further details. The second option is to elect COBRA continuation coverage. 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 since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the 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.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
SCHOOL DISTRICT OF MENOMONEE FALLS
W156 N8480 PILGRAM RD
MENOMONEE FALLS WI 53051

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to waiting periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

This coverage provides for the use of a provider organization. Benefits are paid at the same level regardless of which provider is chosen, but First Health Shared Savings providers have agreed to provide certain discounts on covered services, reducing the Covered Person's out-of-pocket expenses.

The Plan does not limit a Covered Person's right to choose his or her own medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan or is subject to a limitation or exclusion.

To obtain more information on First Health Shared Savings providers, call the number on the back of the Plan's identification card.

- **The Program for Transplant Services at Designated Transplant Facilities is:**

OptumHealth

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

1. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term or if the pregnancy was the result of incest or rape, or the fetus has been diagnosed with a lethal or otherwise significant abnormality.
2. **Allergy Treatment**, including: injections, testing and serum.
3. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital.
4. **Anesthetics and Their Administration.**
5. **Augmentation Communication Devices** and related instruction or therapy.
6. **Autism Spectrum Disorders (ASD) Treatment**, when Medical Necessity is met.

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome, and Pervasive Developmental Disorders.)

ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

Treatment is prescribed and provided by a licensed health care professional practicing within the scope of his or her license (if ABA therapy, preferably a Board Certified Behavior Analyst, or BCBA).

If ABA therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines (for example, ABA treatment up to 25 hours per week for 3-6 months). Treatment plans specific to ABA therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

7. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Benefits for breast pumps include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.
8. **Breast Reductions** if Medically Necessary.
9. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period, and costs for renting breastfeeding equipment.
10. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.
11. **Cardiac Rehabilitation** programs (when Medically Necessary), if referred by a Physician, for patients who have certain cardiac conditions including, but not limited to, the following:
 - the Covered Person had a heart attack in the last 12 months; or
 - the Covered Person had coronary bypass surgery; or
 - the Covered Person had a stable angina pectoris.

Covered services include:

- Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
 - Phase II cardiac 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.
12. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure.
 13. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.
 14. **Cleft Palate and Cleft Lip**, including Medically Necessary oral surgery and pre-graft palatal expanders.
 15. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.
 16. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that a Covered Person self-administers will be processed under the Prescription Drug Benefits section of this document (i.e., oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require that a Physician administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.
 17. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

18. **Dental Services** include:
- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
 - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary.
 - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
19. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.
20. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same for any other Illness.
21. **Durable Medical Equipment**, subject to all of the following:
- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
 - The equipment must be prescribed by a Physician.
 - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
 - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
 - If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
 - due to the growth or development of a Dependent Child;
 - because of a change in the Covered Person's physical condition; or
 - because of deterioration caused from normal wear and tear.The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.
 - This Plan covers taxes and shipping and handling charges for Durable Medical Equipment.
22. **Emergency Room Hospital and Physician Services**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.
23. **Emergency Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office.

24. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

- Room and board.
- Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

25. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

26. **Gender Dysphoria:**

Benefits for the treatment of Gender Dysphoria, limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
- Cross-sex hormone therapy:
 - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
 - Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
- Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
 - Male to Female:
 - Clitoroplasty (creation of clitoris)
 - Labiaplasty (creation of labia)
 - Orchiectomy (removal of testicles)
 - Penectomy (removal of penis)
 - Urethroplasty (reconstruction of female urethra)
 - Vaginoplasty (creation of vagina)
 - Female to Male:
 - Bilateral mastectomy or breast reduction
 - Hysterectomy (removal of uterus)
 - Metoidioplasty (creation of penis, using clitoris)
 - Penile prosthesis
 - Phalloplasty (creation of penis)
 - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
 - Scrotoplasty (creation of scrotum)
 - Testicular prosthesis
 - Urethroplasty (reconstruction of male urethra)
 - Vaginectomy (removal of vagina)
 - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
 - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
 - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
 - The Covered Person must be 18 years of age or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
 - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
 - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
 - The Covered Person must be 18 years of age or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
 - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan must be based on identifiable external sources, including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

27. **Genetic Counseling** based on Medical Necessity.

28. **Genetic Testing** when Medically Necessary (see below).

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. In some cases, testing may be accompanied with pre-test and post-test counseling.

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

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

Generally, genetic testing is not covered for:

- Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
- Informational purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing)
- Experimental, Investigational, or Unproven purposes.

29. **Hearing Services** include:

- Exams, tests, services, and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids.
- Implantable hearing devices including cochlear implants for 18 years of age with bilateral severe to profound sensorineural deafness, or to 18 years of age and certified as deaf or hearing impaired by a Physician or audiologist. Cochlear implants, to include any implantable instrument or device that is designed to enhance hearing, if certified as deaf or hearing impaired.

30. **Home Health Care Services:** (Refer to Home Health Care section of this SPD.)

31. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

- **Assessment**, which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **Outpatient Care**, which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Respite Care** to provide temporary relief to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a terminally ill person when part of an integrated Hospice Care program.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

32. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to Usual and Customary charges, or the Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 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.

33. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 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.

34. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

35. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person.

Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

36. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

37. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

38. **Maternity Benefits** for Covered Persons include:

- Hospital or Birthing Center room and board.
- Vaginal delivery or Cesarean section.
- Non-routine prenatal care.
- Postnatal care.
- Medically Necessary diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Outpatient Birthing Centers.
- Midwives.

39. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

40. **Modifiers or Reducing Modifiers**, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

41. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.
- Bariatric surgery, including, but not limited to
 - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
 - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
 - Lap band (laparoscopic adjustable gastric banding).
 - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
 - Physician-supervised weight loss programs at a medical facility.
 - Charges for diagnostic services.
 - Nutritional counseling by registered dietitians or other Qualified Providers.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

42. **Nursery and Newborn Expenses, Including Circumcision**, are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.
43. **Nutritional Counseling** if Medically Necessary.
44. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through enteral feedings, 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.
45. **Occupational Therapy**. (See Therapy Services below.)
46. **Oral Surgery** includes:
- Excision of partially or completely impacted teeth.
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
 - Reduction of fractures and dislocations of the jaw.
 - External incision and drainage of cellulitis.
 - Incision of accessory sinuses, salivary glands, or ducts.
 - Frenectomy (the cutting of the tissue in the midline of the tongue).
 - Excision of exostosis of jaws and hard palate.
47. **Orthognathic, Prognathic, And Maxillofacial Surgery** when Medically Necessary.
48. **Orthotic Appliances, Devices, and Casts**, including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.
49. **Oxygen and Its Administration**.

50. **Pharmacological Medical Case Management** (medication management and lab charges).
51. **Physical Therapy.** (See Therapy Services below.)
52. **Physician Services** for covered benefits.
53. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.
54. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.
55. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under the applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:
 - Screening for gestational diabetes;
 - Human papillomavirus (HPV) DNA testing;
 - Counseling for sexually transmitted infections;
 - Counseling and screening for human immune-deficiency virus;
 - Screening and counseling for interpersonal and domestic violence; and
 - Breast cancer genetic test counseling (BRCA) for women at high risk.

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/>

56. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

57. **Qualifying Clinical Trials** as defined below, including routine patient care costs 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:

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

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- 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;
- A service that is clearly consistent with widely accepted and established standards of care for a particular diagnosis; and
- 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.

- 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:
 - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
 - Centers for Disease Control and Prevention (CDC);

- Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
 - The Department of Veterans Affairs, the DOD, 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 NIH; and
 - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
 - The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
 - 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
 - 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.

58. **Radiation Therapy and Chemotherapy.**

59. **Radiology and Interpretation Charges.**

60. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital illness or anomaly, by an Accident, or from an infection or other disease of the involved part.

61. **Respiratory Therapy.** (See Therapy Services below.)

62. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

63. **Sexual Function:** Diagnostic services, non-surgical and surgical procedures in connection with treatment for male or female impotence when related to an organic disease.

64. **Sleep Disorders** if Medically Necessary.

65. **Sleep Studies.**

66. **Speech Therapy.** (See Therapy Services below.)

67. **Sterilizations.**

68. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)
69. **Surgery and Assistant Surgeon Services.** (See Modifiers or Reducing Modifiers above.)
- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.
 - If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedure; 50% of the Usual and Customary charge will be allowed for each additional procedure performed through the same incision; and 70% of Usual and Customary charge will be allowed for each additional procedure performed through a separate incision.
 - If multiple unrelated surgical procedures are performed by two more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure.

70. **Temporomandibular Joint Disorder (TMJ) Services** include:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

Coverage does not include orthodontic services.

71. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy when performed by a Qualified Provider.

72. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.
73. **Transplant Services.** (Refer to Transplant section of this SPD.)
74. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.
75. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.
76. **Wigs (Cranial Prosthesis), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.
77. **X-Ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

Refer to the Care Management section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
 - Airfare.
 - Tolls and parking fees.
 - Gas/mileage.
- Lodging at or near the transplant facility, including:
 - Apartment rental.
 - Hotel rental.
 - Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will pay travel and housing benefits for a non-covered living donor only after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

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

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by Express Scripts
Client Service Center Toll Free Number: 800-837-6201
<http://www.express-scripts.com/sdmf>

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your Employer with any questions related to this coverage or service.

IF YOU ARE ELIGIBLE FOR MEDICARE

The School District of Menomonee Falls Prescription drug insurance will terminate the date You become Medicare eligible. You will no longer be eligible for group Prescription drug coverage under this Plan when You become eligible for Medicare even if not enrolled.

Medicare Prescription drug coverage is available to everyone with Medicare. In order to replace Your current group Prescription drug coverage with a Medicare Prescription Drug Plan (Medicare D), You must personally apply for Prescription drug coverage with a carrier that offers Medicare D Prescription Drug coverage or enroll in a Medicare Advantage Plan (like an HMO or PPO) that offers a Medicare D Prescription Drug Plan. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. You can join a Medicare D Prescription Drug Plan when You first become eligible for Medicare. It is important to consider this as soon as You become eligible because, failure to enroll when first eligible may result in paying a penalty (higher premium). Once enrolled, You will be able to switch plans each year from October 15th to December 7th (Medicare open enrollment). Your Dependents who are not Medicare eligible will be able to continue insurance coverage, if eligible, under The School District of Menomonee Falls Prescription drug Plan.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer Prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription drug coverage: Visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If You have limited income and resources, extra help paying for Medicare Prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Additional drug information can be obtained by accessing Express Script’s website at <http://www.express-scripts.com/sdmf> or calling the toll-free customer service number on the back Your ID card.

Medical and Pharmacy Expenses are subject to the same annual Deductible and out-of-pocket maximum. When Your Deductible has been satisfied, the Co-pays as outlined below will be applied. Some maintenance medications will bypass the Deductible and will be paid in full by the Plan. These are all considered “preventive medications” and include the ACA medications as outlined by Healthcare reform. You are allowed 2 maintenance medication fills at retail before You must move to either the Walgreens Smart 90 or to mail order.

DEFINITIONS

The following definitions are used in this Prescription Drug Benefit section:

Brand Name Medication means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by Express Scripts.

Co-payment (Prescription drug) means the amount to be paid by You toward the cost of each separate Prescription or refill of a covered Prescription drug when dispensed by a pharmacy.

Drug List means a list of Prescription drugs, medicines, medications and supplies specified by Express Scripts. This list identifies drugs as Tier 1, Tier 2, or Tier 3 and indicates applicable dispensing limits and/or any prior authorization requirements. Visit Express Script's website at www.express-scripts.com or call the customer service telephone number on Your identification card to confirm if a particular drug is on the drug list. The drug list is subject to change without notice. Because Express Script's drug list is continually updated with Prescription drugs approved or not approved for coverage, You must call the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express-Scripts.com to verify whether a Prescription drug is covered or not covered under this Prescription Drug Benefit Plan.

Formulary means a list of covered brand name and generic Prescription drugs evaluated for efficacy, safety, and cost-effectiveness by Express Scripts.

Generic Medication means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Express Scripts.

Mail Order Pharmacy means a pharmacy that provides covered mail order pharmacy services, as defined by Express Scripts, and delivers covered Prescriptions or refills through the mail to Covered Persons.

Non-Participating Pharmacy means a pharmacy that has NOT signed a direct agreement with Express Scripts to provide covered pharmacy services, covered specialty pharmacy services or covered mail order pharmacy services, as defined by Express Scripts, to Covered Persons, including covered Prescriptions or refills delivered to Your home.

Participating Pharmacy means a pharmacy that has signed a direct agreement with Express Scripts or has been designated by Express Scripts to provide covered pharmacy services, covered specialty pharmacy services or covered mail order pharmacy services, as defined by Express Scripts to Covered Persons, including covered Prescriptions or refills delivered to Your home.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The Prescription must be given by a Qualified Provider to a pharmacist for Your benefit and used for the treatment of a sickness or bodily injury which is covered under this plan or for drugs, medicines or medications on the Women's Healthcare Drug List. The drug, medicine or medication must be obtainable only by Prescription or must be obtained by Prescription for drugs, medicines or medications on the Women's Healthcare Drug List. The Prescription must be given to a pharmacist verbally, electronically or in writing by a Qualified Provider. The Prescription must include at least:

- Your name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the Prescription was prescribed; and
- The name and address of the prescribing Qualified Provider.

Prior Authorization means the required prior approval from Express Scripts for the coverage of Prescription drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the Covered Person's diagnosis, age and sex. Certain Prescription drugs, medicines or medications may require prior authorization. Visit Express Scripts's Website at www.Express-Scripts.com or call the customer service telephone number on Your identification card to determine whether a particular medication requires prior authorization.

Specialty Drug means a drug, medicine, medication or biological used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty drugs may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Specialty Pharmacy means a pharmacy that provides covered specialty pharmacy services, as defined by Express Scripts, to Covered Persons. Express Scripts Specialty Pharmacy is Accredited.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an Employee/eligible Dependent purchases a brand name medication, and an equivalent generic medication is available, the Employee/eligible Dependent must pay the difference between the brand name medication and the generic medication plus any applicable brand name medication Co-payment. If the Qualified Provider indicates on the Prescription "dispense as written", the drug will be dispensed as such, and the Employee/eligible Dependent will only be responsible for the brand name medication Co-payment.

Participating Pharmacy

When a Participating Pharmacy is used and You do not present Your I.D. card at the time of purchase, You must pay the pharmacy the full retail price and submit the pharmacy receipt to Express Scripts at the address listed below. You will be reimbursed at 100% of billed charges after the charge has been reduced by the applicable cost share.

Non-Participating Pharmacy

When a Non-Participating Pharmacy is used, You must pay the pharmacy the full price of the drug and submit the pharmacy receipt to Express Scripts at the address listed below. In addition to the Co-payments shown above, You will be responsible for 30% of the default rate. You are also responsible for 100% of the difference between the default rate and the Non-Participating Pharmacy's charge. The charge received from a Non-Participating Pharmacy for a Prescription or refill may be higher than the default rate.

Mail pharmacy receipts to:

Express Scripts Claims Office Attention:
Pharmacy Department
P.O. Box 14601
Lexington, KY 40512-4601

PRIOR AUTHORIZATION

Some Prescription drugs may be subject to prior authorization. To verify if a Prescription drug requires prior authorization, call the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express-Scripts.com.

DISPENSING LIMITS

Some Prescription drugs may be subject to dispensing limits. To verify if a Prescription drug has dispensing limits, call the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express-Scripts.com.

RETAIL PHARMACY AND SPECIALTY PHARMACY

Your Plan provisions include a retail Prescription drug benefit.

Present Your ID card at a Participating Pharmacy when purchasing a Prescription. Prescriptions dispensed at a retail or specialty pharmacy are limited to the day supply per Prescription or refill as shown on the Schedule of Prescription Drug Benefits.

MAIL ORDER PHARMACY

Your Prescription drug coverage also includes mail order pharmacy benefits, allowing participants an easy and convenient way to obtain Prescription drugs.

Mail order pharmacy Prescriptions will only be filled with the quantity prescribed by Your Qualified Provider and are limited to the day supply per Prescription or refill as shown on the Schedule of Prescription Drug Benefits.

Additional mail order pharmacy information can be obtained by calling the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express-Scripts.com.

OFFICE-ADMINISTERED SPECIALTY DRUGS

Your Qualified Provider has access to specialty drugs used to treat chronic conditions. These drugs can be ordered by Your Qualified Provider specifically for You through Express Scripts's preferred specialty pharmacy vendor for administration in his/her office setting. This allows Your Qualified Provider a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables. Additional information can be obtained by calling the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express-Scripts.com.

MAXIMIZE YOUR BENEFIT

You may receive "Maximize Your Benefit" notifications from Express Scripts regarding possible lower-cost, but equally effective medication alternatives for You to discuss with Your doctor.

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered Prescription expenses incurred by You and Your covered Dependents. Benefits for expenses made by a pharmacy are payable as shown on the Schedule of Prescription Drug Benefits.

You are responsible for:

- Any and all cost share, when applicable;
- The cost of medication not covered under this Prescription Drug Benefit Plan;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

If the dispensing pharmacy's charge is less than the Co-payment, You will be responsible for the lesser amount. The amount paid by this Plan to the dispensing pharmacy may not reflect the ultimate cost to this Plan for the drug. Your cost share is made on a per Prescription or refill basis and will not be adjusted if this Plan receives any retrospective volume discounts or Prescription drug rebates.

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following:

Any drug, medicine, medication or supply not approved for coverage under this Prescription Drug Benefit Plan (call the toll-free customer service phone number on the back of Your ID card or visit Express Scripts's website at www.Express Scripts.com to verify whether a Prescription drug is covered or not covered under this Prescription Drug Benefit Plan). Your Express Scripts ID card can be used as a discount card for Prescription drugs not covered under this Plan;

- Legend drugs which are not deemed medically necessary by a Qualified Provider;
- Charges for the administration or injection of any drug;
- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use," or any drug, medicine or medication that is Experimental, Investigational or for research purposes, even though a charge is made to You;
- Any drug, medicine or medication that is consumed or injected at the place where the Prescription is given, or dispensed by the Qualified Provider;
- Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - Hospital;
 - Skilled nursing facility; or
 - Hospice facility.
- Any drug prescribed, except:
 - FDA approved drugs utilized for FDA approved indications; or
 - FDA approved drugs utilized for off-label drug indications recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.
- Off-evidence drug indications;
- Prescription refills:
 - In excess of the number specified by the Qualified Provider; or
 - Dispensed more than one year from the date of the original order.
- Any drug for which a charge is customarily not made;
- Therapeutic devices or appliances, including, but not limited to: hypodermic needles and syringes (except needles and syringes for use with insulin and covered self-administered injectable drugs, whose coverage is approved by this Plan); support garments; test reagents; mechanical pumps for delivery of medications; and other non-medical substances;
- Dietary supplements (except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease); nutritional products; fluoride supplements; minerals; herbs; and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride);
- Drug delivery implants;

- Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or self-administered injectable drugs or specialty drugs not covered under this Prescription Drug Benefit Plan;
- Any drug prescribed for a sickness or bodily injury not covered under this Plan;
- Any portion of a Prescription or refill that exceeds the day supply as shown on the Schedule of Prescription Drug Benefits;
- Any drug, medicine or medication received by the Covered Person:
 - Before becoming covered under this Plan; or
 - After the date the Covered Person's coverage under this Plan has ended;
- Any costs related to the mailing, sending, or delivery of Prescription drugs;
- Any intentional misuse of this benefit including Prescriptions purchased for consumption by someone other than the Covered Person;
- Any Prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;
- Repackaged drugs;
- Any drug or medicine that is:
 - Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or
 - Available in Prescription strength without a Prescription.
- Any drug or biological that has received designation as an orphan drug, unless approved by this Plan;
- Any amount You paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;
- Any portion of a Prescription or refill that exceeds the drug specific dispensing limit, is dispensed to a Covered Person whose age is outside the drug specific age limits, is refilled early or exceeds the duration-specific dispensing limit;
- Any drug for which prior authorization is required and not obtained;
- Based on the dosage schedule prescribed by the Qualified Provider, more than one Prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more Qualified Providers and dispensed by one or more pharmacies until You have used, or should have used, at least 75% of the previous Prescription or refill. If the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, until You have used, or should have used, at least 66% of the previous Prescription or refill. (Based on the dosage schedule prescribed by the Qualified Provider);
- Any amount exceeding the default rate.

HEARING AID BENEFITS

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 EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC at its toll-free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct him or her to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services not covered under the Plan out-of-pocket prior to the delivery of services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact EPIC directly at its toll-free number or write to: EPIC Hearing Services, 3191 W. Temple Ave. Ste. 200, Pomona, CA 91768.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for a psychiatric condition. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

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

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.
- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
 - Personality disorders; or
 - Behavior and impulse control disorders; or
 - "V" codes (including marriage counseling).
- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance related disorders. (Coverage does not include services provided in a community based residential facility, or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located, or a therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special 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. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

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

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness, and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Management Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces or orthotics, over \$1,500 or Durable Medical Equipment rentals over \$500 per month.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- MRI, MRA, CT, and PET scans.
- Dialysis.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of \$250 may be applied to applicable claims, except MRI, MRA, CT and PET scans, if a Covered Person receives services but does not obtain the required Prior Authorization.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Case management opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during 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. Information is easily passed from utilization management to case management through our fully integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Disease Management Program

The **Disease Management Program** identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with Covered Persons to help them improve their chronic diseases and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and depression as a comorbidity linked to another chronic condition we manage). Built within our system is a predictive modeling tool, Aerial Analytics and Clinical Intelligence Rules, that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates may be initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referrals, other Care Management programs, NurseLine referrals, the employer, or the Covered Person's Physician.

In addition to the telephonic services, UMR Disease Management also provides HealthNotes. These targeted mailings are sent to Covered Persons' homes and their health care providers via U.S. Mail. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs. Opportunities or gaps in care are identified through medical and/or pharmacy data.

HealthNotes provides useful, personalized information based on an individual Covered Person's health care utilization, including information on provider visits, Prescriptions, and health screenings.

HealthNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall health care costs.

Case Management

Case Management Services are designed to identify catastrophic and complex illnesses, transplants, and trauma cases. UMR Care Management's nurse case managers identify, coordinate, and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during 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 Management 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.

NurseLine/Nurse Chat

NurseLine is a health information line that is available 24-hour-per-day, 7-day-per-week, that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

Nurse Chat is an online source of health and wellness information that is available 24-hour-per-day, 7-day-per-week. Covered Persons have one-on-one secure, real-time access to registered nurses through the Health Center on umr.com. These nurses provide information on a variety of health and wellness topics. Note: Triage is not part of the Nurse Chat experience. If a Covered Person needs triage assistance, Nurse Chat refers the Covered Person to NurseLine.

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) provides access to a preferred provider dialysis network and support from UMR Case Management by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR Case Management End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.
- If an individual is covered under one plan as a Dependent and another plan as an Employee, member, or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.
- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
 - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive Employee: If an individual is covered under one plan as an active Employee (or Dependent of an active Employee), and is also covered under another plan as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee), the plan that covers the person as an active Employee (or Dependent of an active Employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)
- Longer or Shorter Length of Coverage: The plan that has covered the person as an Employee, member, subscriber, or retiree the longest is primary.
- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

When this Plan is not primary and a Covered Person is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payments on Medicare Part B services as though Medicare Part B was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
 - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
 - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
 - You are no longer actively employed by an employer; and
 - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
 - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
 - You or Your covered spouse has retiree coverage plus Medicare coverage; or
 - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

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 health insurance plan.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

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.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape, or the fetus has been diagnosed with a lethal or otherwise significant abnormality.
2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment.**
4. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.
5. **Appointment Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy.**
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services,** unless determined to be Medically Necessary by the Plan.
9. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.
10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.
11. **Bereavement Counseling.**
12. **Biofeedback Services.**
13. **Blood:** Blood donor expenses.
14. **Blood Pressure Cuffs / Monitors.**
15. **Breast Pumps,** unless covered elsewhere in this SPD.
16. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
17. **Chelation Therapy,** except in the treatment of conditions considered to be Medically Necessary, medically appropriate, and not Experimental, Investigational, or Unproven for the medical condition for which the treatment is recognized.
18. **Claims** received later than 12 months from the date of service.
19. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

20. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.
21. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.
22. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony for which the individual is charged.
23. **Custodial Care** as defined in the Glossary of Terms of this SPD.
24. **Dental Services:**
 - The care and treatment of teeth or gums, or alveolar processes, dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges, including professional charges for X-rays, labs, and anesthesia; to charges for treatment of Injuries to natural teeth, including replacement of such teeth with dentures; or to charges for the setting of a jaw that was fractured or dislocated in an Accident.
 - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
 - Dental implants including preparation for implants unless due to accidental Injury.
25. **Duplicate Services and Charges or Inappropriate Billing**, including the preparation of medical reports and itemized bills.
26. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.
27. **Employment / Workers' Compensation:** An Illness or Injury arising out of, or in the course of, any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, where required by state law.
28. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.
29. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.
30. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.
31. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.
32. **Extended Care:** Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.
33. **Family Planning:** Consultations for family planning.
34. **Financial Counseling.**

35. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.
36. **Foot Care (Podiatry):** Routine foot care.
37. **Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency.
38. **Gender Dysphoria:**
- Cosmetic procedures, including the following:
- Abdominoplasty.
 - Blepharoplasty.
 - Breast enlargement, including augmentation mammoplasty and breast implants.
 - Body contouring, such as lipoplasty.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.
 - Injection of fillers or neurotoxins.
 - Face lift, forehead lift, or neck tightening.
 - Facial bone remodeling for facial feminizations.
 - Hair removal.
 - Hair transplantation.
 - Lip augmentation.
 - Lip reduction.
 - Liposuction.
 - Mastopexy.
 - Pectoral implants for chest masculinization.
 - Rhinoplasty.
 - Skin resurfacing.
 - Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's Apple).
 - Voice modification surgery.
 - Voice lessons and voice therapy.
39. **Genetic Counseling** other than based on Medical Necessity, unless covered elsewhere in this SPD.
40. **Genetic Testing,** unless covered elsewhere in this SPD.
41. **Growth Hormones.**
42. **Home Births** and associated costs.
43. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.
44. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

45. **Infertility Treatment:**

- Fertility tests.
- Surgical reversal of a sterilized state that was a result of a previous surgery.
- Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs.
- Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
- Embryo transfer.
- Freezing or storage of embryo, eggs, or semen.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered person.

46. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

47. **Lamaze Classes** or other childbirth classes.

48. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

49. **Liposuction**, regardless of purpose.

50. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

51. **Mammoplasty or Breast Augmentation**, unless covered elsewhere in this SPD.

52. **Marriage Counseling.**

53. **Massage Therapy.**

54. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

55. **Military:** A military-related illness of or injury to a Covered Person on active military duty, unless payment is legally required.

56. **Nocturnal Enuresis Alarm** (Bed wetting).

57. **Non-Custom-Molded Shoe Inserts.**

58. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

59. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

60. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

61. **Nutrition Counseling**, unless covered elsewhere in this SPD.
62. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.
63. **Over-the-Counter Medication, Products, Supplies, or Devices**, unless covered elsewhere in this SPD.
64. **Palliative Foot Care.**
65. **Panniculectomy / Abdominoplasty**, unless determined by the Plan to be Medically Necessary.
66. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.
67. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.
68. **Preventive / Routine Care Services**, unless covered elsewhere in this SPD.
69. **Private Duty Nursing Services**, unless Inpatient Hospital services are Medically Necessary and if the Hospital does not have an Intensive Care Unit or if the Intensive Care Unit is full.
70. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.
71. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.
72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
74. **Self-Administered Services** or procedures that can be performed by the Covered Person without the presence of medical supervision.
75. **Self-Inflicted Injuries or Illnesses**, unless due to, medical conditions (physical or mental) or domestic violence.
76. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
77. **Services** that should legally be provided by a school.
78. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.
79. **Sex Therapy.**
80. **Sexual Function:** Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.
81. **Standby Surgeon Charges.**

82. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.
83. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.
84. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.
85. **Telemedicine - Telephone or Internet Consultations.**
86. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.
87. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
88. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.
89. **Vision Care,** unless covered elsewhere in this SPD.
90. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.
91. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
92. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.
93. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.
94. **Wigs (Cranial Protheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.
95. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to obtain approval from the Plan *before* obtaining the medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or 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.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or urgent care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or urgent care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan, and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.

- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If you have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e. to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.UMR.com to assist you in providing all the recommended information to ensure a full and fair review of your adverse benefit determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
EXPRESS SCRIPTS
ATTN: BENEFIT COVERAGE REVIEW DEPT
PO BOX 66587
ST LOUIS MO 63166-6587

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence 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 we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

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 applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a Wellness Program;
- 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); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails 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 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 to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

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, if applicable; (4) a description of 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.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You, 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 qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR 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:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order 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 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 required by applicable law.

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.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else-such as the Covered Person's spouse or another family member-files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers 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 precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Director of Human Resources, Human Resources Manager, Human Resources Coordinator, Payroll Manager, Director of Finance and Operations

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Human Resources or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birth Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's or Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means an Employee, Retiree, or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delays may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Domestic Partner means unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; 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, if applicable.

Experimental, Investigational, or Unproven means any drug, service, supply, care, 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:

- 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 service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been 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;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that 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, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care 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.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
 - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):
 - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - A strong preference for cross-gender roles in make-believe play or fantasy play.
 - A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
 - A strong preference for playmates of the other gender.
 - In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; 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 an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

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, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician 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 means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease, or symptoms

The fact that a Physician 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 will 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 the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

Morbid Obesity means a Body Mass Index (BMI) that is greater than or equal to 40 kg/m². If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by, obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI greater than or equal to 35 kg/m² is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

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

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the SCHOOL DISTRICT OF MENOMONEE FALLS Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law. For a High Deductible Health Plan, Preventive/Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a high deductible health plan (HDHP) without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or treatment of mental health/substance use disorders. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

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

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means 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.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means a person who was employed full-time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.

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

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Disease – Clinical Modification manual (ICD-CM) in the following categories:
 - Personality disorders; or
 - Behavior and impulse control disorders; or
 - “V” codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means 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.

Walk-In Retail Health Clinics means 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 a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.