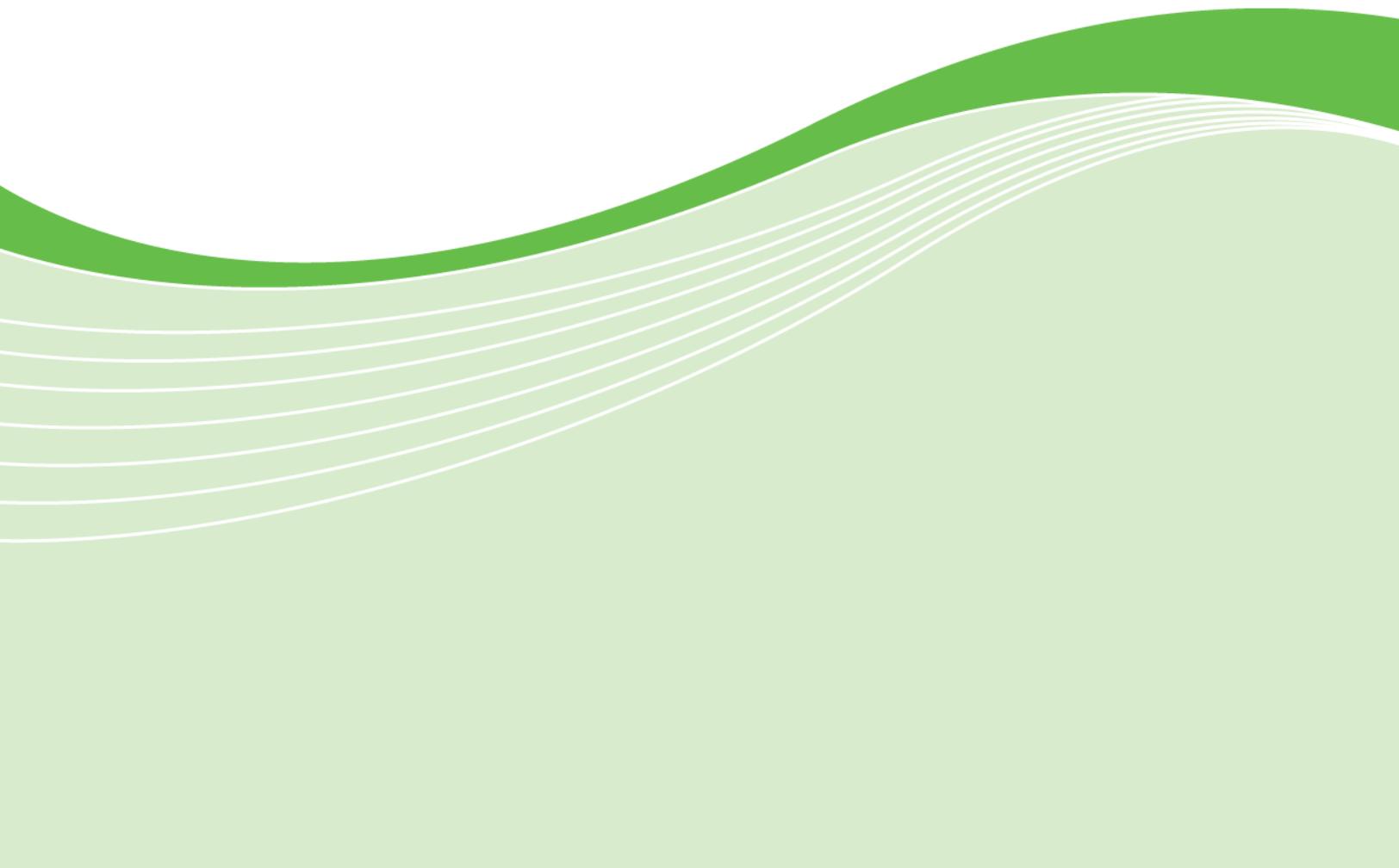




**WCA Group Health Trust  
Marinette County  
Medical Benefit Plan**

Group Number: WCA0038  
Effective: January 1, 2010





**SUMMARY PLAN DESCRIPTION**

**EMPLOYEE MEDICAL PLAN FOR**

**WCA GROUP HEALTH TRUST**  
**MARINETTE COUNTY**

**GROUP NUMBER: WCA0038**

**Underwritten By:**  
WCA Group Health Trust  
22 East Mifflin Street Suite 900  
Madison, Wisconsin  
(866) 404-2700 (toll-free)

**Effective Date: January 1, 2010**

\_\_\_\_\_  
**Authorized County Representative**

\_\_\_\_\_  
**Authorized Representative,  
WCA Group Health Trust**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

**SIGNED**

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# Your Online Benefits Service from UMR

Your online benefits service provides you with convenient access to the information you need when you need it. You'll have 24/7 access to these great services:

- Claim status
- ID card ordering
- Health information
- Your Online Provider Directory
- Frequently used forms
- And so much more! See details on back.

## Accessing Online Services

It's easy and fast to access your online benefits service at [www.umar.com](http://www.umar.com). Complete the instructions below.

### New members

1. Go to [www.umar.com](http://www.umar.com) and click **Login/Register**.
2. Enter your member ID (displayed on your benefits ID card). If you don't have an ID card, enter your Social Security number.
3. Click **Go to my online services**.
4. Follow the on-screen prompts; click **Sign-Up** to enter additional information and complete your registration.
5. Explore the site's features and view information about your benefits and claims.
6. Click **Logoff** near the top of the homepage when you're ready to leave the site.



(continued on back)





#### Registered members

1. Go to **www.umar.com** and click **Members**.
2. Enter your member ID (located on your benefits ID card). If you don't have an ID card, enter your Social Security number.
3. Click **Go to my online services**.
4. Follow the on-screen prompts; enter your current **Username** and **Password**.
5. Click the online benefits service site's features and services, as before.
6. Click **Logoff** near the top of the homepage when you're ready to leave the site.

*Your online benefits service provides helpful, time-saving health and benefits information. Click the menu selections and site features to become familiar with the site and all that it has to offer.*

#### Key features of your online benefits service

##### Provider lookup:

Find in-network providers by clicking Find A Provider under the All Members selection on My Menu.

##### Claims:

Access claims information for you and your covered dependents from the My Benefits selection on My Menu.

##### Eligibility:

View eligibility coverage information and effective dates for you and covered dependents at the eligibility service under My Benefits.

##### Get answers:

Use the Ask UMR A Question feature under My Benefits for email access to your Customer First Service Team.

##### Health information:

Help you and your family stay healthier and be wiser health care consumers by exploring links to reliable health and medical information. Click Health Info in the menu at the top of the homepage.

##### News:

Check the online benefits service's homepage for current benefits-related news and announcements from UMR and your employer.



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# TABLE OF CONTENTS

## SECTION 1 MEDICAL BENEFITS

---

PAYMENT OF COVERED EXPENSES	1-1
<b>AN IMPORTANT MESSAGE ABOUT YOUR PLAN</b>	<b>1-2</b>
CERTIFICATION PROCEDURES	1-2
MEDICAL BILL REVIEW	1-2
<b>SCHEDULE OF BENEFITS</b>	<b>1-3</b>
MEDICAL BENEFITS	1-3
<b>MEDICAL BENEFITS</b>	<b>1-11</b>
DEDUCTIBLE AND COINSURANCE INFORMATION	1-11
<b>MEDICAL COVERED EXPENSES</b>	<b>1-12</b>
INPATIENT HOSPITAL BENEFITS	1-12
QUALIFIED PRACTITIONER BENEFITS	1-12
ORAL SURGERY	1-13
CERTAIN DENTAL SERVICES	1-13
WELLNESS BENEFIT	1-14
ROUTINE IMMUNIZATIONS	1-14
SUPPLEMENTAL ACCIDENT BENEFIT	1-15
OUTPATIENT HOSPITAL BENEFIT	1-15
URGENT CARE CENTER BENEFIT	1-15
AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY	1-15
X-RAY AND LABORATORY TESTS	1-15
AMBULANCE SERVICE BENEFIT	1-15
PREGNANCY BENEFIT	1-16
NEWBORN BENEFITS	1-16
BIRTHING CENTER BENEFIT	1-17
HOME HEALTH CARE BENEFIT	1-17
CONVALESCENT NURSING HOME BENEFIT	1-18
HOSPICE CARE BENEFIT	1-18
HUMAN ORGAN AND TISSUE TRANSPLANTS	1-19
PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT	1-20
OTHER COVERED EXPENSES	1-22
<b>MEDICAL LIMITATIONS AND EXCLUSIONS</b>	<b>1-27</b>
ALTERNATIVE TREATMENTS	1-27
DENTAL	1-27
DRUGS	1-27
EXPERIMENTAL OR UNPROVEN SERVICES	1-27
PHYSICAL APPEARANCE	1-28
PRE-EXISTING CONDITIONS	1-28
PROVIDERS	1-28
REPRODUCTION	1-29
ROUTINE AND GENERAL HEALTH	1-29

SERVICES UNDER ANOTHER PLAN	1-29
OTHER	1-30

<b>PRESCRIPTION DRUG CARD</b>	<b>1-32</b>
-------------------------------	-------------

**SECTION 2   DEFINITIONS**

---

<b>DEFINITIONS</b>	<b>2-1</b>
--------------------	------------

**SECTION 3   ELIGIBILITY**

---

<b>ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE</b>	<b>3-1</b>
---	------------

ANNUAL ENROLLMENT	3-1
EMPLOYEE ELIGIBILITY	3-1
EMPLOYEE EFFECTIVE DATE OF COVERAGE	3-2
DEPENDENT ELIGIBILITY	3-2
DEPENDENT EFFECTIVE DATE OF COVERAGE	3-2
ANNUAL ENROLLMENT PERIOD	3-3
RETIREE COVERAGE (UNION)	3-4
RETIREE COVERAGE (NON-UNION)	3-5
SPECIAL ENROLLMENT RIGHTS	3-5
MEDICAID/STATE CHILD HEALTH PLAN	3-6
SPOUSAL TRANSFER PROVISION	3-6
BENEFIT CHANGES	3-7
SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK	3-7
REINSTATEMENT OF COVERAGE	3-7
EXTENSION OF BENEFITS	3-8
SURVIVORSHIP CONTINUATION – WPPA UNION	3-9
SURVIVORSHIP CONTINUATION – NON UNION	3-9
TERMINATION OF COVERAGE	3-10

<b>FAMILY AND MEDICAL LEAVE ACT (FMLA)</b>	<b>3-11</b>
--	-------------

EMPLOYEE ELIGIBILITY	3-11
TYPES OF LEAVE	3-11
REINSTATEMENT OF COVERAGE UPON RETURN TO WORK	3-12
DEFINITIONS	3-12

<b>UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)</b>	<b>3-14</b>
---	-------------

CONTINUATION OF COVERAGE DURING MILITARY LEAVE	3-14
REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE	3-14

<b>CONTINUATION OF BENEFITS</b>	<b>3-16</b>
---------------------------------	-------------

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)	3-16
AMERICAN RECOVERY AND REINVESTMENT ACT	3-20
ELIGIBLE INDIVIDUALS	3-21
AMOUNT AND LENGTH OF SUBSIDY	3-21

ELECTING THE SUBSIDY	3-22
ELECTING DIFFERENT COVERAGE	3-22

<b>INDIVIDUAL MEDICAL CONVERSION PRIVILEGE</b>	<b>3-23</b>
--	-------------

**SECTION 4   GENERAL PLAN INFORMATION**

---

<b>COORDINATION OF BENEFITS</b>	<b>4-1</b>
---------------------------------	------------

<b>RECOVERY RIGHTS</b>	<b>4-4</b>
------------------------	------------

GENERAL RECOVERY RIGHTS PROVISIONS	4-4
------------------------------------	-----

<b>GENERAL PROVISIONS</b>	<b>4-6</b>
---------------------------	------------

ALTERNATE RECIPIENTS	4-6
----------------------	-----

AMENDMENTS TO OR TERMINATION OF THE PLAN	4-6
--	-----

ASSIGNMENT	4-6
------------	-----

CLAIM REVIEW PROCEDURE	4-6
------------------------	-----

CLERICAL ERROR	4-7
----------------	-----

CONFORMITY WITH APPLICABLE LAWS	4-7
---------------------------------	-----

CONTRIBUTIONS TO THE PLAN	4-7
---------------------------	-----

COOPERATION	4-7
-------------	-----

FAILURE TO ENFORCE PLAN PROVISIONS	4-7
------------------------------------	-----

FREE CHOICE OF PROVIDER	4-8
-------------------------	-----

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT	4-8
---	-----

LEGAL ACTIONS	4-8
---------------	-----

PAYMENT OF CLAIMS	4-8
-------------------	-----

PHYSICAL EXAMINATION	4-8
----------------------	-----

PRIVACY OF PROTECTED HEALTH INFORMATION	4-8
---	-----

PROOF OF LOSS	4-11
---------------	------

PROTECTION AGAINST CREDITORS	4-11
------------------------------	------

REPRESENTATIONS	4-12
-----------------	------

RIGHT TO NECESSARY INFORMATION	4-12
--------------------------------	------

SECURITY	4-12
----------	------

TERMINATION OF THE PLAN	4-12
-------------------------	------

TIME OF CLAIM DETERMINATION	4-12
-----------------------------	------

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## **SECTION 1 MEDICAL BENEFITS**

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## **PAYMENT OF COVERED EXPENSES**

The plan will pay for your covered expenses to the extent provided in the plan for the benefits selected by the covered employee, subject to deductibles, copayments, maximums, and all other terms, provisions, limitations, conditions and exclusions of the plan.

## **AN IMPORTANT MESSAGE ABOUT YOUR PLAN**

### **CERTIFICATION PROCEDURES**

The Utilization Management company (UM) shown on your ID card will handle the certification requirements of your plan. You should call UM as soon as possible to receive proper certification. The UM toll-free number is on the back of your ID card. For additional information, call UM.

**Non-Emergency Inpatient Admissions:** You should notify UM in advance of any non-emergency inpatient admission to a qualified treatment facility. (No penalty will be applied if the UM is not notified.)

**Emergency Inpatient Admissions:** You should notify UM within the first business day after any emergency inpatient admission to a qualified treatment facility. (No penalty will be applied if the UM is not notified.)

**Chemotherapy and Kidney Dialysis:** You should notify UM before you begin any chemotherapy or radiation services. (No penalty will be applied if the UM is not notified.)

### **Maternity Admissions (Newborns and Mothers Health Protection Act)**

Your stay for delivery is protected under federal law. Certification is not required unless your stay exceeds 48 hours for a normal vaginal delivery or 96 hours for a caesarian section delivery. Admissions that exceed these time limits must be certified by UM as stated above.

Certification by UM is not a guarantee of coverage.

### **MEDICAL BILL REVIEW**

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

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bill, with the errors circled, and the corrected bill to the claim administrator. This serves as proof that the provider of service agreed to the corrections. **If you are correct, you will receive 25% of the errors in the bill, but not more than \$1,000 paid per bill.**

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

## SCHEDULE OF BENEFITS

**Medical Plan - Lifetime Maximum:** \$2,000,000 per covered person.

### MEDICAL BENEFITS

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per calendar year PPO Individual Family  Non-PPO Individual Family	  \$0 \$0  \$0 \$0	  \$250 \$500  \$250 \$500	The amount you must pay each year before the plan will begin paying any benefits.  PPO and Non-PPO family maximums are on an aggregate dollar basis.	1-11
<b>WPPA and retirees Prior To 9/15/2009</b>  Individual coinsurance per calendar year PPO  Non-PPO	  90% 80%	  10% 20%	After the deductible, the coinsurance amounts shown apply. After which the plan pays 100% of covered expenses subject to any maximums.	1-11
<b>All other active employees and retirees after 9/15/2009</b>  Individual coinsurance per calendar year PPO  Non-PPO	  90% 70%	  10% 30%	After the deductible, the coinsurance amounts shown apply. After which the plan pays 100% of covered expenses subject to any maximums.	1-11

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
<p><b>County Board and retirees prior to 1/1/2006</b></p> <p>Out-of-Pocket limit per calendar year</p> <p style="padding-left: 40px;">PPO Individual Family</p> <p style="padding-left: 40px;">Non-PPO Individual Family</p>		<p style="padding-left: 40px;">\$350 \$700</p> <p style="padding-left: 40px;">\$700 \$1,400</p>	<p>Represents the total paid by you for the <b>coinsurance</b>. After which the plan pays 100% of covered expenses subject to any maximums. (The deductible is <u>not</u> included in the out-of-pocket limit. It is in addition to it.)</p> <p>PPO and Non-PPO family maximums are on an aggregate dollar basis.</p>	1-11
<p><b>All other employees and retirees after 1/1/2006</b></p> <p>Out-of-Pocket limit per calendar year</p> <p style="padding-left: 40px;">PPO Individual Family</p> <p style="padding-left: 40px;">Non-PPO Individual Family</p>		<p style="padding-left: 40px;">\$350 \$700</p> <p style="padding-left: 40px;">\$1,500 \$3,000</p>	<p>Represents the total paid by you for the <b>coinsurance</b>. After which the plan pays 100% of covered expenses subject to any maximums. (The deductible is <u>not</u> included in the out-of-pocket limit. It is in addition to it.)</p> <p>PPO and Non-PPO family maximums are on an aggregate dollar basis.</p>	1-11
<p>All covered expenses under the plan are payable at the plan's usual, customary and reasonable limits. The deductible and coinsurance limits shown above apply to all covered expenses unless stated otherwise below.</p> <p><b>PPO Benefit Provision</b> PPO Benefits will be payable for Non-PPO provider services <b>only</b> if:</p> <ol style="list-style-type: none"> <li>1. You require emergency medical care.</li> <li>2. The required medical services are not available from a PPO provider.</li> <li>3. PPO benefits will be payable for Non-PPO provider services only if you receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred from a Non-PPO provider that is a: pathologist; anesthesiologist; cardiologist; radiologist or emergency Room physician and independent labs.</li> </ol>				

**Schedule of Benefits - continued**

<b>COVERED EXPENSES</b>	<b>PAYABLE AT</b>	<b>BENEFIT SUMMARY</b>	<b>TEXT PAGE</b>
Inpatient Hospital Benefit	Subject to the deductible and coinsurance	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-12
Qualified Practitioner Benefits	Subject to the deductible and coinsurance	Inpatient and outpatient hospital visits, home and office visits, surgery and anesthesia.	1-12
Oral Surgery	Subject to the deductible and coinsurance	Refer to list of covered oral surgeries in text.	1-13
Certain Dental Services	Subject to the deductible and coinsurance	Refer to the text for a list of covered services.	1-13

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	<p><b>PPO &amp; Non-PPO:</b> 100%, deductible and coinsurance waived, up to the calendar year limit. <b>Then</b> subject to the deductible and coinsurance for the rest of that calendar year.</p> <p>Mammograms, Pap Smears, PSA Tests &amp; Colonoscopies: <b>1<sup>st</sup> per calendar year:</b> 100%, deductible and coinsurance waived, up to the stated calendar year limits. <b>Then</b> subject to the deductible and coinsurance for the rest of that calendar year.</p> <p><b>Additional in the same calendar year:</b> Subject to the deductible and coinsurance</p>	<p><b>Calendar year limits</b> (then subject to the deductible and coinsurance for the rest of that calendar year):</p> <ul style="list-style-type: none"> <li>▪ <b>WPPA &amp; retirees prior to 9/15/2009:</b> \$600 paid per calendar year.</li> <li>▪ <b>All other active employees and retirees after 9/15/2009:</b> \$1,000 paid per calendar year.</li> </ul> <p>Benefits include routine physical exams, well child care, routine x-ray and laboratory tests, routine mammograms, routine pap smears, routine PSA tests, routine colonoscopies, routine exams for school, sports and camps, third-party exams and treatments and blood lead tests for a dependent under age six years exams.</p> <p><u>Refer to the text for details and limits.</u></p> <p><b>X-rays and Lab Tests:</b> All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-14
Routine Immunizations	100%, deductible and coinsurance waived (for PPO and Non-PPO)	For any Covered Person.	1-14
Supplemental Accident Benefit	100%, deductible and coinsurance waived	Limited to \$500 paid per accident. (Any additional covered expenses for that accident will be subject to the deductible and coinsurance.)	1-15
Outpatient Hospital Benefit	Subject to the deductible and coinsurance		1-15

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p><b>All other active employees and retirees after 9/15/2009:</b> \$50 copay per visit, then subject to the deductible and coinsurance</p> <p><b>WPPA and retirees prior to 9/15/2009:</b> Subject to the deductible and coinsurance. (No copay)</p>	<p>This copay does not apply to the out-of-pocket limit.</p> <p>Benefits include all covered expenses performed during the visit.</p> <p>This copay is waived if you are admitted to the hospital from the emergency room.</p> <p>Emergency room treatment is limited to emergencies, as defined in this plan.</p>	1-15
Urgent Care Center Benefits	Subject to the deductible and coinsurance	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all covered expenses performed during the visit.	1-15
Ambulatory Surgical Center	Subject to the deductible and coinsurance		1-15
X-ray and Laboratory Tests	Subject to the deductible and coinsurance	<p>Dental x-rays limited to covered oral surgery or Injury.</p> <p>All covered medical x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-15
Ambulance Service Benefit	PPO Deductible/ 90% to the PPO coinsurance limit (all providers)	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.	1-15
Pregnancy Benefit	Subject to the deductible and coinsurance	Covered for employee, spouse and dependents.	1-16

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Newborn Benefits	<p><b>Well Baby:</b> 100%, deductible and coinsurance waived (for PPO and Non-PPO)</p> <p><b>Sick Baby:</b> Subject to the deductible and coinsurance</p>	See "Section 3 – Eligibility" for important information on dependent coverage.	1-16
Birthing Center Benefit	Subject to the deductible and coinsurance		1-17
Home Health Care Benefit	Subject to the deductible and coinsurance		1-17
Convalescent Nursing Home Benefit	Subject to the deductible and coinsurance	Limited to 30 days per calendar year.	1-18
Hospice Care Benefit	Subject to the deductible and coinsurance		1-18
Human Organ and Tissue Transplants	<p><b>Transplant Network Benefits:</b> 100%, deductible and coinsurance waived</p> <p><b>Outside of the Transplant Network</b> Subject to the deductible and coinsurance</p>	Refer to the list of covered transplants in the text.	1-19
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other sickness or injury		1-20
Other Covered Expenses	Subject to the deductible and coinsurance		1-22

Medical - Effective January 1, 2010

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	Subject to the deductible and coinsurance	<p>Limited to 25 visits per calendar year, including routine or maintenance care.</p> <p>Additional visits may be covered if they are medically necessary. (This does not include routine or maintenance care.)</p>	1-22
Physical, Speech, Occupational and Respiratory Therapy	Subject to the deductible and coinsurance	Refer to the text for more information.	1-22
Diabetic Supplies and Education	<p><b>Supplies:</b> PPO deductible/90% to the PPO coinsurance limit</p> <p><b>Self-Management Education:</b> Subject to the deductible and coinsurance</p>	<b>Supplies:</b> Covered under the medical plan only if they are not covered under the prescription drug card.	1-23
TMJ Benefit	Subject to the deductible and coinsurance	<p>Covers diagnostic and non-surgical treatment.</p> <p><b>Surgical Treatment:</b> Payable as shown under the oral surgery benefit.</p>	1-23
<p>Vision Benefit (Exams, Glasses and Contact Lenses)</p> <p><b>The following locations do not have these vision benefits: 0010, 0556, 0887</b></p>	100%, deductible and coinsurance waived (for PPO and Non-PPO)	<p><b>Note: The following locations do not have these vision benefits: 0010, 0556, and 0887.</b></p> <p>Limited to \$100 paid per calendar year.</p> <p>Benefits include exams, refractions, eyeglasses, contact lenses and charges for radial keratotomy and Lasik surgery to correct refractive disorders.</p>	1-23
Office Visits for Smoking Cessation Prescriptions	100%, deductible and coinsurance waived (for PPO and Non-PPO)	<p>Includes services that are necessary to obtain a prescription for smoking cessation drugs.</p> <p>The medical plan does not cover charges for counseling related to nicotine addiction or smoking cessation or hypnosis that is related to nicotine addiction or smoking cessation.</p>	1-26

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Limitations and Exclusions	Not Payable	List of exclusions that apply to all covered expenses.	1-27
Prescription Drug Card	100%, after copay  Copays apply per drug/refill.	<p><b>Retail:</b> 34-day supply per drug/refill  <b>Mail Order:</b> 90-day supply per drug/refill</p> <p><b>Retail :</b>  Generic: \$7 copay  Brand Name: \$15 copay</p> <p><b>Mail Order:</b>  Generic: \$12 copay  Brand Name: \$20 copay</p> <p><b>Mandatory Generic Substitution:</b> If you choose to receive a brand name drug when a generic substitute is available, you will have to pay the difference between the cost of the brand name drug and the cost of the generic substitute in addition to the copay amount. If the provider writing the prescription or the state where you live does not allow generic substitution or a generic drug is not available, only the brand name copayment will apply (and not the difference between the cost of the generic and the cost of the brand name).</p>	1-32

# **MEDICAL BENEFITS**

## **DEDUCTIBLE AND COINSURANCE INFORMATION**

Covered expenses are payable, after satisfaction of the deductible, on a usual, customary and reasonable basis at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

### **Deductible**

The deductible applies to each covered person, each calendar year. Only charges that are a covered expense will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

### **4<sup>th</sup> Quarter Deductible Carryover Credit**

Any covered expense Incurred during the last three months of the calendar year that is used to satisfy all or part of the deductible for that year may be used to satisfy all or part of the deductible for the following calendar year.

### **Common Accident Deductible**

When two or more covered persons in one family incur covered expenses due to the same accident, only one deductible per calendar year will be applied to all covered expenses of the family incurred as a result of that accident.

### **Maximum Family Deductible**

The total deductible applied to all covered persons in one family, in a calendar year, is subject to the maximum shown on the Schedule of Benefits. Once your family reaches this maximum for a calendar year, no further deductibles will be applied during that calendar year.

### **Coinsurance**

Benefits are payable at the percentage shown on the Schedule of Benefits, after the deductible is satisfied each calendar year. Benefits are payable for the rest of the calendar year or up to any plan maximums, on a usual, customary and reasonable basis, at the percentage rate shown on the Schedule of Benefits.

### **Out-of-Pocket Limit**

The amount you must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of the coinsurance only. (The deductible is not included in the out-of-pocket limit. It is in addition to it.) When the out-of-pocket limit has been met for a covered person or family, the plan will pay 100% of covered expenses for the rest of the calendar year. If you use PPO and Non-PPO providers, PPO covered expenses will be applied to both out-of-pocket limits. Your out-of-pocket expense for a calendar year will not exceed the Non-PPO limit.

This limit does not apply to:

1. Penalties for failure to comply with the Utilization Review Plan;
2. Benefit specific copays under the plan;
3. Charges in excess of the usual, customary and reasonable amount.

## **MEDICAL COVERED EXPENSES**

### **INPATIENT HOSPITAL BENEFITS**

Charges made for the following services or supplies furnished by a hospital are payable as shown on the Schedule of Benefits.

#### **Room and Board**

Average daily semi-private; ward; intensive care; isolation or coronary care room charges and general nursing services for each day of confinement. Benefits for a private room are limited to the average charge for a semi-private room in the hospital where you are confined. When the facility has private rooms only or a private room is medically necessary, the private room rate will be considered.

#### **Hospital Miscellaneous Charges**

Charges made by the hospital on its own behalf for services and supplies furnished for your treatment during confinement, including the following charges made by a qualified practitioner, whether billed directly by the hospital or separately:

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

### **QUALIFIED PRACTITIONER BENEFITS**

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

1. Home and office visits;
2. Inpatient and outpatient hospital visits;
3. A surgical procedure or multiple or bilateral surgical procedures, wherever performed, including pre- and post-operative care.

Subsequent surgical procedures (i.e. suture or cast removal), which are normally considered part of the usual, customary and reasonable fee for the initial surgery will only be considered for payment as a separate service when performed by a qualified practitioner other than the operating surgeon.

4. Reconstructive surgery when due injury, infection or other disease of the involved part, or due to congenital disease or anomaly which resulted in a functional defect or due to a previous therapeutic process;
5. Elective sterilizations, vasectomies and tubal ligations;
6. Assistant surgeon services, if medically necessary; and
7. Administration of anesthesia, when rendered by a provider who is licensed to perform such services. covered expenses include services rendered by a Certified Registered Nurse Anesthetist (CRNA).

## **ORAL SURGERY**

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

1. Surgical exposure or extraction of partially or completely unerupted impacted teeth;
2. Excision of exostosis of the jaw and hard palate;
3. Apicoectomy (excision of the apex of the tooth root);
4. External incision and drainage of cellulitis;
5. Incision of accessory sinuses, salivary glands or ducts;
6. Gingivectomy (excision of loose gum tissue to eliminate infection);
7. Alveolectomy (the leveling of structures supporting teeth for the purpose of fitting dentures);
8. Frenectomy (the cutting of tissue in the midline of the tongue);
9. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
10. Surgical procedures required to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth; and
11. Reduction of fractures and dislocations of the jaw and excision of the temporomandibular joints;
12. Repair of or initial replacement of natural teeth damaged due to injury or illness. Damage resulting from biting or chewing will not be considered an injury.

## **CERTAIN DENTAL SERVICES**

Charges made for the following dental services are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays.

1. Surgery by a dentist for the removal of impacted or unerupted teeth;
2. Services by a dentist for the setting of jaw fractures;
3. Extraction of seven or more natural teeth at one time;
4. Charges for dental implants. Covered only when they are necessary for the restructuring of the mouth and to restore function;
5. Dental procedures that are required due to the treatment of a sickness or injury (e.g. cancer, infection of the jaw, bone, facial structure or structure of the mouth). Covered expenses include, but are not limited to:
  - a. extraction of teeth and
  - b. bridges, dentures or other standard dental treatment if the treatment is consistent with the treatment plan for your sickness or injury and is performed for the purpose of restoring bodily functions.) and

### **Certain Dental Services - continued**

6. Services of a hospital or ambulatory surgical center due to dental care. To be a covered expense, the services must be provided to:
  - a. a dependent child under the age of five years,
  - b. a covered person with a chronic disability,
  - c. a covered person with a medical condition that requires hospitalization for such dental care, or
  - d. a covered person with a medical condition that requires general anesthesia, for such dental care.

Anesthetics related to the dental care will also be covered.

### **WELLNESS BENEFIT**

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Covered expenses include:

1. Routine physical exams;
2. Routine x-ray and laboratory tests;
3. Routine mammograms for any covered female person;
4. Routine pap smears for any covered female person;
5. Routine PSA tests and exams for any covered male person. Limited to once per calendar year;
6. Well child care services as prescribed by a qualified practitioner;
7. Blood lead tests for covered dependent children under the age of six years. Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services;
8. Routine exams required for school, sports and camps;
9. Routine endoscopic surgeries (e.g. colonoscopies);
10. Third-party exams and treatments, such as those required for employment and the purchase of insurance; and
11. Charges for services that are performed pursuant to state statute or regulation for the purpose of determining the appropriateness of voluntary or involuntary commitment or detention.

You must not be confined in a hospital or qualified treatment facility and such expenses must not be for the diagnosis or treatment of a specific injury or sickness.

### **ROUTINE IMMUNIZATIONS**

Payable as shown on the Schedule of Benefits. For any Covered Person.

## **SUPPLEMENTAL ACCIDENT BENEFIT**

Covered expenses due to injuries from one accident are payable at 100%. This benefit is subject to the limit shown on the Schedule of Benefits. Covered expenses in excess of the limit will be payable at the deductible and coinsurance.

## **OUTPATIENT HOSPITAL BENEFIT**

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

1. Services and supplies provided for the treatment of your sickness or injury;
2. Pre-admission testing services;
3. Diagnostic x-rays and laboratory services;
4. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by your attending qualified practitioner; and
5. Emergency room charges.

## **URGENT CARE CENTER BENEFIT**

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

## **AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY**

Charges made by a free-standing surgical facility or ambulatory surgical center, on its own behalf, for surgical procedures performed and for hospital miscellaneous services provided in the facility.

## **X-RAY AND LABORATORY TESTS**

Diagnostic x-ray and laboratory tests when performed by a qualified practitioner and not covered under the Hospital Miscellaneous Charges provision. This provision does not include any dental x-rays, unless related to a covered injury or illness.

## **AMBULANCE SERVICE BENEFIT**

Charges for ground ambulance service to a local hospital are payable as shown on the Schedule of Benefits. If you need care that is not available in a local hospital, transport to the nearest hospital that can provide the care is covered. If you require care that is not available by ground ambulance, air ambulance service to the nearest hospital that can provide the care is covered.

## **PREGNANCY BENEFIT**

Pregnancy is a covered expense for any covered female person. Covered expenses are payable as shown on the Schedule of Benefits. Complications of pregnancy are payable, for any covered female person, as any other sickness at the point the complication sets in.

Hospital and qualified practitioner services in performing therapeutic abortions are a covered expense under this benefit. Charges for an abortion will be covered if the life of the mother would be endangered if the fetus were carried to term and when the pregnancy is the result of incest or rape. Elective abortions are not covered under this plan. Services related to complications of elective and medically necessary abortions are covered expenses.

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

## **NEWBORN BENEFITS**

This benefit does not apply unless you enroll your newborn dependent within 60 days of the date of birth. Please refer to Section 3 – Eligibility of this plan for more information.

A newborn child of a covered employee is covered during the first 60 days of life. Dependent coverage **must** be in force for coverage to continue past the first 60 days of life. If dependent coverage is not in force at the end of the 60 days, the child's coverage will terminate immediately. However, coverage may still be effective on the child's date of birth if the following conditions are met: Coverage is applied for within 12 months of the child's date of birth and all back contributions due plus 5 1/2% interest are paid.

### **Well Newborn**

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

### **Sick Newborn**

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

1. Reconstruction due to injury, infection or other disease of the involved part; or
2. Congenital disease or anomaly of a covered dependent child which resulted in a functional defect.

Medical - Effective January 1, 2010

## **BIRTHING CENTER BENEFIT**

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

## **HOME HEALTH CARE BENEFIT**

Expense incurred for home health care, as described below, is payable as shown in the Schedule of Benefits.

The maximum weekly benefit for such coverage will not exceed the usual, customary and reasonable fee for weekly care in a convalescent nursing home facility.

Each visit by a person providing services under a home health care plan or evaluating the need for, or developing a plan of home health care will be considered as one home health care visit.

Up to four consecutive hours of home health aide service in a 24-hour period is considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof.

Home health care will **not** be reimbursed unless the qualified practitioner certifies that:

1. Necessary care and treatment are not available from members of your immediate family or other persons residing with you, without causing undue hardship; and
2. The home health care services will be provided or coordinated by a state-licensed or Medicare-certified home health care agency or certified rehabilitation agency.

If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must also be initially recommended by the qualified practitioner who was the primary provider of services during your hospitalization.

The home health care plan may consist of:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
2. Part-time or intermittent home health aide services which are necessary as part of the home health care plan, provided under the supervision of a registered nurse (R.N.) or medical social worker, and which consist solely of caring for the patient;
3. Physical, respiratory, occupational or speech therapy;
4. Medical supplies, drugs and medications prescribed by a qualified practitioner and laboratory services by or on behalf of a hospital, when necessary under the home care plan and to the extent such items would be covered under the plan if you had been hospitalized;
5. Nutritional counseling provided under the supervision of a registered dietician, when such services are necessary as part of the home care plan;
6. The evaluation of the need for and the development of a plan of home health care by a registered nurse (R.N.), physician assistant or medical social worker; when home health care is recommended or requested by your attending qualified practitioner; and
7. Pic line (Waiting for specific language regarding this.)

## **Home Health Care Benefit - continued**

### **Limitations**

Home health care services do **not** include:

1. Services or supplies not included in the home health care plan;
2. Services of a family member;
3. Custodial care;
4. Food, housing, homemaker services or home delivered meals; or
5. Transportation services.

## **CONVALESCENT NURSING HOME BENEFIT**

Expense incurred for daily room and board and general nursing services for each day of confinement in a convalescent nursing home is payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility where you are confined. (Refer to the definition of convalescent nursing home for more information.)

## **HOSPICE CARE BENEFIT**

Charges for these hospice care services are payable as shown on the Schedule of Benefits. Hospice care must be in lieu of a covered hospital or convalescent nursing home confinement.

1. Room and board and related services and supplies;
2. Part-time nursing care by or supervised by a registered nurse (R.N.);
3. Medical social services provided to you or your immediate family. Services include:
  - a. assessment of social, emotional and medical needs, and the home and family situation, and
  - b. identification of the community resources available and assisting in obtaining those resources;
4. Dietary counseling;
5. Consultation and case management services;
6. Physical or occupational therapy;
7. Home health care and related supplies;
8. Part-time home health aide service; and
9. Medical supplies, drugs and medicines prescribed by a qualified practitioner.

### **Limitations**

Hospice Care must be furnished in a hospice facility or by a hospice care agency in your home. A qualified practitioner must certify that you are terminally ill with a life expectancy of six months or less.

## **Hospice Care Benefit - continued**

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

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

## **HUMAN ORGAN AND TISSUE TRANSPLANTS**

The following human organ or tissue transplants are payable when the transplant is provided from a human donor to a living human transplant recipient and the attending qualified practitioner certifies the medical necessity of the transplant:

1. Bone marrow transplants, when not experimental or investigational. The covered person must request in advance, from the plan, a determination as to whether a bone marrow transplant is covered or is excluded as experimental or investigational;
2. Cornea transplants;
3. Arteries or veins;
4. Heart transplants;
5. Heart lung transplants (combined procedures);
6. Kidney transplants;
7. Liver transplants;
8. Lung transplants;
9. Pancreas transplants;
10. Kidney pancreas transplants (combined procedures);
11. Small bowel transplants; and
12. Any other tissue or organ transplant that may be covered elsewhere in this Plan.

**NOTE: THE *PLAN* SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS *YOU* ARE AWARE OF THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR *YOU*. ACCESS TO THE TRANSPLANT NETWORK IS SUBJECT TO *PLAN'S* ONGOING COORDINATION.**

The plan will provide you with a list of transplant network facilities. It will help to coordinate your referral and access to the facility of your choice. Only facilities that are participating in the transplant network at the time of your admission are transplant network facilities.

## **Human Organ and Tissue Transplants - continued**

### **Special Transplant Network Benefits**

If a transplant network Facility is used, the plan will cover the following expenses, in addition to the regular transplant benefits that are available under this plan:

- a. Access to the transplant network facilities, in addition to any employer-contracted transplant facilities within the state of Wisconsin,
- b. Waiver of the covered person's deductible and coinsurance, up to \$1500 during the year that your transplant was incurred,
- c. Travel expenses to and from the designated transplant network facility for the covered person and one companion (or both parents if the covered person is a minor child). Such travel expenses must be related to the actual transplant services; and
- d. Lodging and meal expenses at or near the specified transplant facility for the companion who accompanied the covered person (or parents who accompanied the covered person who is a minor child). Lodging is only covered while the covered person is confined at the transplant facility.

Benefits for travel, lodging and meals are limited to a combined maximum of \$5,000 paid per transplant for the covered person and companion (or parents of a minor child) combined. More information on the transplant network will be provided to you as part of the pre-certification process for a transplant procedure.

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

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

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

If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue. However, other costs related to the evaluation and procurement are covered for a recipient who is covered under this plan. Benefits are not payable if they are available from another plan, an organization or Medicare.

## **PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT**

The following expenses incurred by you during a plan of treatment for a psychological disorder, chemical dependence or alcoholism are payable as stated below:

1. Charges made by a qualified practitioner;
2. Charges made by a hospital; and
3. Charges made by a qualified treatment facility.

Medical - Effective January 1, 2010

## **Psychological Disorders, Chemical Dependence and Alcoholism Benefit – continued**

### **Inpatient Benefits**

Covered expenses while confined as a registered bed patient in a hospital or qualified treatment facility are payable as shown on the Schedule of Benefits.

### **Transitional Treatment Benefits**

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

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

Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services for alcohol and chemical dependence provided by a residential treatment program; and services for alcoholism and other chemical dependence provided in a day treatment program.

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

### **Outpatient Benefits**

Covered expenses for outpatient treatment received while not confined in a hospital or qualified treatment facility are payable as shown on the Schedule of Benefits. Outpatient benefits include related expenses for diagnostic lab tests and psychological testing. Outpatient benefits also include collateral interviews with the family of the covered person who is being treated. All treatment must be related to the diagnosed condition. Prescription drugs are payable under the prescription drug benefit.

### **Limitations**

Benefits do **not** include:

1. Treatment of nicotine habit or nicotine addiction;
2. Marriage counseling; or
3. Court ordered examinations or counseling.

## **OTHER COVERED EXPENSES**

These other covered expenses are payable as shown on the Schedule of Benefits:

1. Chiropractic care for the treatment of an Injury or Sickness. Routine or maintenance chiropractic care is covered as shown on the Schedule of Benefits.
2. Anesthesia and anesthesia services and supplies. Services must be rendered by a provider who is licensed to perform such services. Covered expenses include services rendered by a Certified Registered Nurse Anesthetist (CRNA).
3. Treatment by a licensed: physical therapist; speech therapist; respiratory therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an injury or sickness, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders. Speech therapy is covered only when the therapy is required for your job or profession, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders.
4. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for nursing care ordered by your attending qualified practitioner. The nurse must not ordinarily reside in your home or be a family member.
5. Rental/Purchase of Equipment:
  - a. Oxygen and rental of equipment for its administration; rental of equipment to treat respiratory paralysis,
  - b. Rental of radioactive substances,
  - c. Rental, up to the total purchase price, or, when approved by the plan, purchase of a wheelchair, hospital bed, respirator or other durable medical equipment. Benefits are payable for the medically necessary equipment that is adequate for your condition. The equipment must be needed for therapeutic treatment, be able to withstand repeated use, primarily and customarily used to serve a medical purpose, and not generally useful to a person except for the treatment of an injury of sickness. Repair expenses are not covered. Maintenance expenses are not covered. Convenience items, as determined by the plan, are not covered. Unless approved by the plan benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.
6. Initial purchase of prosthetic devices and supplies to replace lost natural limbs and eyes. Limited to one device every two calendar years (per each device purchased.) Replacement devices will only be covered when approved by the plan. Repair expenses are covered only when they are required to restore proper function to the device. Maintenance expenses are not covered.
7. Special supplies when prescribed by your attending qualified practitioner and necessary for the continuing treatment of a sickness or injury, such as
  - a. Catheters,
  - b. Colostomy bags, rings and belts,
  - c. Flotation pads.
8. Charges for ostomy supplies.
9. Charges for casts, splints, trusses, orthopedic braces and crutches.

Medical - Effective January 1, 2010

## Other Covered Expenses - continued

10. Custom molded orthotics.
11. Charges for the first pair of glasses or contact lenses for aphakia, keratoconus or following cataract surgery.
12. Blood and blood plasma, except for that of the covered person or that which has been donated specifically for the covered person.
13. Diabetic equipment and supplies, unless they are covered under the Prescription Drug Card. The installation and use of an insulin infusion pump. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before the initial purchase. Diabetic self-management education programs are covered.
14. Temporomandibular Joint (TMJ) diagnostic and non-surgical treatment. Benefits include appliances and therapy for any jaw joint problem, including any temporomandibular joint disorder, craniomaxillary or craniomandibular disorder or other conditions of the jaw joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof, including headaches. These covered expenses do not include cosmetic or elective orthodontic care, periodontal care or general dental care. (Note: Surgical treatment is payable as shown under the Oral Surgery benefit.)
15. Outpatient radiation therapy.
16. Chemotherapy.
17. Pre-admission testing.
18. Charges for a second surgical opinion.
19. Expenses incurred by a covered person during participation in a Cancer Clinical Trial when the expense would be a covered expense if provided outside of the trial (e.g. lab tests for blood cell counts, CAT scans and MRIs to monitor the progress of the cancer, and anti-nausea medications).
20. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:
  - a. reconstruction of the breast that was removed,
  - b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
  - c. prostheses to replace the breast that was removed, and
  - d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the plan.
21. Routine vision exams. Includes refractions, eyeglasses and contact lenses and charges for radial keratotomy or Lasik surgery to correct refractive disorders. Benefits are subject to the limits shown on the Schedule of Benefits. Contact lens solutions and contact lens supplies are not covered expenses under this Plan. (**Note:** The following locations do not have these vision benefits: 0010, 0556 or 0887.)
22. Treatment of morbid obesity. Covered only when medically necessary. Obesity is defined by your Body Mass Index (BMI). BMI is obtained by dividing your weight in kilograms by your height in meters squared. A BMI greater than 30 is considered obese. A BMI greater than 35 is considered to be severe obesity. A BMI greater than 40 is considered to be morbid obesity.

## Other Covered Expenses - continued

23. Hospital admission kits.
24. Charges for injections of medications related to a covered sickness or injury.
25. Services and supplies, including the rental of kidney dialysis equipment incurred for kidney dialysis treatment.
26. Charges or taxes legally imposed by a governmental entity, including those calculated on the amount of eligible charges paid for a covered person under this plan.
27. Podiatry charges for the complete removal of a toenail.
28. Birth control, when not covered by the prescription drug card. Covered expenses include but are not limited to birth control pills, implants, injections, intrauterine devices (IUDs), cervical caps, and diaphragms. You must obtain a prescription from your qualified practitioner or other licensed health care professional. The medical plan also covers related charges such as consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive. The plan does not cover drugs, services or supplies that can be obtained without a prescription from a qualified practitioner or other licensed health care professional, such as condoms and contraceptive foam or gel. (**Note: Birth control that is covered under the prescription drug card is not a covered expense under the medical plan.**)
29. Hearing aids, cochlear implants and related treatment for a covered dependent child under the age of 18 years old, if the child is certified as deaf or hearing impaired by a qualified practitioner or audiologist. This benefit is not subject to the Pre-Existing Conditions limitation. Covered expenses include:
  - a. the cost of hearing aids and cochlear implants that are prescribed by a qualified practitioner or audiologist, in accordance with accepted professional medical or audiological standards,
  - b. the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, and
  - c. One hearing aid per ear every three calendar years.
30. Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and non-intensive-level services.

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

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

### **Intensive Level Services**

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

## **Other Covered Expenses – continued**

- a. based upon a treatment plan developed by a qualified practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the covered person be present and engaged in the intervention,
- b. implemented by qualified practitioners, qualified supervising provider, qualified professional, qualified therapists or qualified paraprofessionals,
- c. provided in an environment most conducive to achieving the goals of the covered person's treatment plan,
- d. included training and consultation, participation in team meeting and active involvement of the covered person's family and treatment team for implementation of the therapeutic goals developed by the team,
- e. commenced after a covered person is two years of age and before nine years of age,
- f. the covered person is directly observed by the qualified practitioner at least once every two months.

Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the covered person, regardless of payor, may be applied to the required four years. The plan may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the covered person received for autism spectrum disorders prior to age nine.

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

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

### **Non-Intensive Level Services**

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

- a. after the completion of intensive-level services and designed to sustain and maximize gains made during intensive level services treatment,
- b. to a covered person who has not and will not receive intensive-level services but for whom non-intensive level services will improve the covered person's condition.

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

- a. based upon a treatment plan developed by a qualified practitioner, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the covered person be present and engaged in the intervention,
- b. implemented by qualified practitioners, qualified supervising providers, qualified professionals, qualified therapist or qualified paraprofessionals,

## Other Covered Expenses – continued

- c. provided in an environment most conducive to achieving the goal of the covered person's treatment plan,
- d. included training and consultation, participation in team meetings and active involvement of the covered person's family in order to implement the therapeutic goals developed by the team,
- e. provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

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

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

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

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

- a. the maximum four-year limit has been met,
- b. intensive-level services are no longer supported by the documentation provided by the qualified practitioner,
- c. the covered person no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

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

The following services are not covered under the autism spectrum disorders:

- a. acupuncture,
- b. animal-based therapy including hippotherapy,
- c. auditory integration training,
- d. chelation therapy,
- e. child care fees,
- f. cranial sacral therapy,
- g. custodial or respite care,
- h. hyperbaric oxygen therapy,
- i. special diets or supplements,
- j. pharmaceuticals and durable medical equipment.

31. Charges for the services that are necessary to obtain a prescription for smoking cessation drugs. Charges for nicotine patches are covered under the medical plan if the patches are not covered under the prescription drug card. (The prescription drugs are not covered under the medical plan. They may be covered under the prescription drug card. The medical plan does not cover charges for counseling related to nicotine addiction or smoking cessation or hypnosis that is re related to nicotine addiction or smoking cessation. Over-the-counter products are not covered under the medical plan, except as specifically stated for nicotine patches.)
32. Functional repair or restoration to any body part when necessary to achieve normal bodily function.

Medical - Effective January 1, 2010

## **MEDICAL LIMITATIONS AND EXCLUSIONS**

This Plan does **not** provide benefits for:

### **ALTERNATIVE TREATMENTS**

1. Any charge for alternative medical treatments. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of arsenic, gold, mercury or lead poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy, herbal therapy, vitamin therapy, biofeedback and hypnotherapy; or
2. Acupuncture; Acupuncture therapy.

### **DENTAL**

1. Dental care or treatment, except as specifically described; or for orthognathic surgery, including osteotomy procedures of the maxilla and mandible; or
2. Dental implantology techniques, including prosthetic devices related to such techniques, except as specifically stated for the restructuring of the mouth and to restore bodily function.

### **DRUGS**

1. Drugs, food or nutritional supplements, or medical or other supplies that are available without the written prescription of a qualified practitioner (OTC - over the counter). OTC items specifically stated in this plan as a covered expense will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a qualified practitioner's office, hospital or other facility it will be covered; or
2. Charges for prescription drugs, except when not covered by the County's prescription drug card and not excluded under any other provision of this plan.

### **EXPERIMENTAL OR UNPROVEN SERVICES**

1. Any drug or medicine which is not approved for marketing by the United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration. This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection;
2. Any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States; or
3. Any medical or surgical procedure which as of the time services are performed is conducted consistent with an experimental or investigative protocol of the United States Department of Health and Human Services or any of its subsidiary Agencies, Bureaus, Institutes or Divisions.

## **Limitations and Exclusions – continued**

### **PHYSICAL APPEARANCE**

1. Plastic or cosmetic surgery, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to Injury, infection or other disease of the involved part is a covered expense when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;
2. Any charges for, relating to or resulting from sex change operations;
3. Treatment of a congenital disease or anomaly, except to correct a functional defect;
4. Wigs or artificial hairpieces, hair transplants; drugs for the treatment of hair loss;
5. Any treatment or services for weight control or reduction. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; or
6. Any treatment of obesity, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy). (Note: Treatment of morbid obesity is a covered expense as shown under the Other Covered Expenses.)

### **PRE-EXISTING CONDITIONS**

1. Pre-Existing conditions, to the extent specified in the definitions section.

### **PROVIDERS**

1. Any service or supply:
  - a. provided while you are not under the regular care of a qualified practitioner,
  - b. not authorized or prescribed by a qualified practitioner,
  - c. authorized or prescribed by a qualified practitioner, but excluded under this plan;
2. Services provided by a person who ordinarily resides in your home or who is a family member;
3. Telephone, computer or Internet consultations between you and any provider. Completion of claim forms or forms necessary for your return to work or school. Any appointment you did not attend;
4. Private duty nursing, except as stated under the home health care benefit;
5. Charges by a provider for pre-admission certification or concurrent stay review;
6. Charges for medical summaries or finance charges in connection with a claim;
7. Charges that are over the usual and customary fee for medical records fees; or
8. Charges for services that are provided during home births when they are provided by anyone other than a qualified practitioner.

## **Limitations and Exclusions - continued**

### **REPRODUCTION**

1. Elective abortions performed by any means including surgical and pharmaceutical methods. (Note: Charges for an abortion will be covered if the life of the mother would be endangered if the fetus were carried to term and when the pregnancy is the result of rape or incest.) (Services related to complications of elective and medically necessary abortions are covered.)
2. Any artificial means to achieve pregnancy including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs. (Note: Diagnostic testing up to the original diagnosis of infertility is a covered expense. Once the initial diagnosis of infertility is determined, no additional infertility testing will be covered);
3. Treatment, services or supplies for a surrogate mother or any pregnancy resulting from your service as a surrogate mother;
4. Genetic testing or counseling, unless medically necessary to treat the sickness or injury of a covered person or used in the treatment of a high risk pregnancy; or
5. The reversal of elective or medically necessary sterilization procedures.

### **ROUTINE AND GENERAL HEALTH**

1. Vision therapy (orthoptics);
2. Charges for routine hearing tests; hearing aids or the fitting or repair of any hearing aid (Note: Certain hearing aids, cochlear implants and related treatment are payable as specifically stated under the Other Covered Expenses)
3. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine addiction, except as specifically stated under the Other Covered Expenses; or
4. Charges for the removal of corns or calluses or trimming of nails.

### **SERVICES UNDER ANOTHER PLAN**

1. Any injury or sickness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any Workers' Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;
2. Any service or supply for which no charge is made, or for which you would not be required to pay if you did not have this coverage;
3. Any charges that would have been paid by your primary plan had you complied with all of the pre-certification requirements of that plan;
4. Any service or supply provided by or payable under any plan or law of any government or any political subdivision (this does not include Medicare or Medicaid); or

## **Limitations and Exclusions - continued**

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

## **OTHER**

1. Charges in excess of the usual, customary and reasonable charge for the service or supply;
2. Services not medically necessary for diagnosis and treatment of an injury or sickness;
3. Custodial care, domiciliary care and rest cures;
4. Any medical expense incurred before your effective date of coverage under this plan after the date your coverage under the plan terminates, except as specifically described;
5. Charges incurred outside the United States if you traveled to such location to obtain the service, drug or supply; travel for health; charges for services provided outside of the United States, except for emergency treatment;
6. Any medical expense due to commission or attempt to commit a civil or criminal battery or felony;
7. Any loss caused or contributed to by:
  - a. war or any act of war, whether declared or not, or
  - b. any act of international armed conflict, or any conflict involving armed forces of any international authority;
8. Educational testing or training, vocational training or recreational therapy;
9. Any human organ or tissue transplant except as stated. Any non-human organ transplant. Any artificial organ transplant;
10. Charges for marriage counseling;
11. Inpatient hospital admissions which are primarily for physical therapy or for diagnostic studies;
12. Personal hygiene or convenience items;
13. Charges for the purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts;
14. Any room and board charges resulting from your admission to a hospital or qualified treatment facility on a Friday, Saturday or Sunday, unless your admission is on an emergency basis, or surgery is scheduled for that day or the next day or such admission is related to pregnancy;

## **Limitations and Exclusions - continued**

15. Any service or supply provided in connection with or as a result of any service or supply that is not a covered expense; except as specifically stated under the Other Covered Expenses (e.g. the Cancer Clinical Trial benefit). The plan covers treatment for complications of elective and medically necessary abortions; or
16. The following services are not covered when they are related to the autism spectrum disorders benefit:
  - a. acupuncture,
  - b. animal-based therapy including hippotherapy,
  - c. auditory integration training,
  - d. chelation therapy,
  - e. child care fees,
  - f. cranial sacral therapy,
  - g. custodial or respite care,
  - h. hyperbaric oxygen therapy,
  - i. special diets or supplements,
  - j. pharmaceuticals and durable medical equipment.

## **PRESCRIPTION DRUG CARD**

You will receive an identification (ID) card. It will show your name, ID number, group number and effective date.

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

### **Covered Drugs**

Your drug card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." Your pharmacist or the prescribing physician can verify coverage for a drug by contacting the drug card service at the number on your ID card. A complete list of covered and excluded drugs is available on the drug card's web site. If you are unable to access the drug card's web site, the County will provide a copy upon request at no charge.

### **How To Use The Prescription Drug Card**

Present the ID card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If you are without your ID Card or at a non-participating pharmacy, you may be required to pay for the prescription and submit a claim to the drug card service. Claim forms are available from the County.

### **Mail Order Drug Service**

If you are using an ongoing prescription drug, you may purchase that drug on a mail order basis. Most drugs covered by the drug card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an on going medical condition and are taken on a regular basis.

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

Mail order prescriptions should be sent to the drug card service. Order forms are available at the drug card web site or from the County. All prescriptions will be mailed directly to your home.

## **SECTION 2 DEFINITIONS**

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## DEFINITIONS

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

### ***Accident***

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

### ***Actively at Work***

An employee is actively at work if he or she is employed by the County and meets the minimum requirements set by the County for eligibility under this plan, except that an employee is not considered actively at work if he or she has been laid off or is absent from work for reasons other than those which entitle those employees to leave under Family and Medical Leave laws or a Health Factor, and such layoff or absence from work is for such a period of time that the employee is not longer eligible for the benefits of the plan pursuant to the rules or policies established by the County or the terms of any applicable collective bargaining agreement. (**Note:** Refer to the definition of “employee” for additional information.)

### ***Ambulatory Surgical Center***

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

### ***Amendment***

A document, duly authorized by the plan administrator, that changes any provision of the plan.

### ***Birthing Center***

A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the birthing center; 2. Is directed by a qualified practitioner specializing in obstetrics and gynecology; 3. Has a qualified practitioner or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to qualified practitioners who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area hospital for emergency transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program and 13. Keeps a medical record for each patient.

### ***Business Associate***

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

## **Definitions – continued**

### ***Calendar Year***

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

### ***Chronic Disability***

A disability which meets all of the following requirements: 1) It is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) It is likely to continue indefinitely; 3) It results in substantial functional limitations in one or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, capacity for independent living and economic self sufficiency.

### ***Claims Administrator***

The person or entity employed by the plan administrator to provide administrative services in connection with the operation of the plan and any other functions including the processing of claims. If no claims administrator is employed by the plan administrator, claims administrator will mean the plan administrator.

### ***Complications of Pregnancy***

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

### ***Confinement***

Being a resident patient in a hospital for at least 15 consecutive hours per day or being a resident bed patient in a convalescent nursing home or other qualified treatment facility 24 hours a day. Successive confinements are considered one if:

1. Due to the same injury or sickness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

### ***Convalescent Nursing Home (Skilled Nursing Facility or Extended Care Facility)***

An institution or part of an institution, which is lawfully run in the jurisdiction where it is located and maintains and provides:

1. Permanent and full-time bed care facilities for resident patients;
2. A qualified practitioner's services available at all times;
3. A registered nurse (R.N.) or qualified practitioner in charge and on full-time duty and one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and

## **Definition of Convalescent Nursing Home - continued**

5. Continuous skilled nursing care for sick or injured persons during their convalescence from sickness or injury.

Convalescent nursing home does not include an institution which is principally a rest home or a home for care of the aged, or a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

### ***Convalescent Nursing Home Confinement***

Convalescent nursing home confinement is only a confinement in a convalescent nursing home which:

1. Begins within 24 hours after discharge from a hospital confinement or prior convalescent nursing home confinement;
2. Is necessary for care or treatment of the same injury or sickness which caused the prior hospital confinement; and
3. Occurs while you or your covered dependent are under the regular care of the qualified practitioner certified the required convalescent nursing home confinement.

### ***County***

The County or other governmental unit, identified on the cover page, which employs the covered employee.

### ***Covered Dependent***

An Employee's eligible Dependent who is properly enrolled in the Plan.

### ***Covered Employee***

An employee who is eligible and properly enrolled in the plan.

### ***Covered Expense***

Expense incurred by you or your covered dependent for services or supplies provided by a qualified practitioner or qualified treatment facility due to an injury or sickness if the expense Incurred is covered by the plan.

### ***Covered Person***

A covered employee or covered dependent.

### ***Custodial Care***

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

## Definitions – continued

### *Dependent*

1. A covered employee's lawful spouse, as defined in the state where you reside, provided that:
  - a. the spouse is not legally separated from the employee, and
  - b. the employee is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;
2. A covered employee's unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the employee's legal guardianship by court order; or a child placed with the employee for the purpose of adoption and for which the employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

**The limiting age for each dependent child is 27 years**, provided such child is not married **and** is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a dependent under the this plan).

Coverage may be extended (beyond age 27) for a dependent child if **all** of the following requirements are met:

- a. the dependent child is a full-time student, regardless of age, and
- b. the dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a dependent under the employee), and
- c. the dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. the dependent child was under age 27 when called to federal active duty.

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

1. the date the child's coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

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

3. A covered employee's grandchild. The parent of the child must be a covered dependent child who is not yet 18 years old for the grandchild to be covered.

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

1. The child is mentally retarded or physically handicapped;
2. The child is incapable of self-sustaining employment because of the mental retardation or physical handicap;
3. The child is chiefly dependent on the covered employee for support and maintenance; and

## **Definition of Dependent - continued**

4. The child never married.

You must provide satisfactory proof that the above conditions exist within 31 days after the date the limiting age is reached. The plan administrator may request such proof annual after two years from the date the limiting age is reached. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

No person may be covered as both an employee and a dependent at the same time. If both the employee and spouse are eligible for coverage under this plan, only one may enroll for dependent coverage.

### ***Effective Date***

The effective date stated on the front of this plan.

### ***Emergency***

Any injury or sickness which requires immediate treatment and which if not immediately treated would jeopardize or impair the health of the covered person. An emergency may or may not be life threatening.

### ***Employee***

You when you are: regularly employed by the County, are paid a salary or earnings by the County; and actively at work. For purposes of this plan, employee does not include independent contractors, leased employees or any employee who is temporary, unless otherwise approved by the County. For the purposes of this plan, employee includes the following:

- **Employees - Except Library Union:** Includes full-time employees, permanent part-time employees, permanent seasonal employees and Marinette County employed elected officials. (The required number of hours worked to be eligible for the plan are determined by the employer.)
- **Library Union Employees:** This includes either: a) employees working at least 600 hours per year, on a regular basis, or b) employees who were covered under the plan prior to May 31, 2006, regardless of the number of hours worked. Part-time (except as specified), temporary, and leased employees are not eligible for coverage under this plan.
- **Marinette County employed elected officials.**
- **Limited Term Employees:** Such employees working less than 600 hours per year are not eligible for coverage under this plan.
- **Certain Retired Employees:** According to the terms of your current collective bargaining agreement or employment contract.
- **Other persons employed at the discretion of the County.**

### ***Employer***

Marinette County.

### ***Enrollment Date***

The first day of your eligibility period or if earlier, your effective date of coverage under this plan. If you are a late applicant, your enrollment date is the effective date of your coverage under this plan.

Medical - Effective January 1, 2010

## **Definitions - continued**

### ***Expense Incurred***

The amount charged for services and supplies needed to treat the injury or sickness. The expense incurred date is the date a supply or service is provided.

### ***Family***

A covered employee and the covered employee's covered dependents.

### ***Family Member***

Your lawful spouse, child, parent, grandparent, brother or sister, or any person related in the same way to your covered dependent.

### ***Health Factor***

The health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including whether an individual is a victim of domestic violence or engages in activities, such as motorcycling, horseback riding, snowmobiling or similar activities, or disability of and employee or dependent of any employee.

### ***Home Health Care***

Medical care or treatment provided by a home health care agency to you in your home due to your sickness or injury and pursuant to a home health care plan, or services of a qualified practitioner or home health care agency in evaluating the need for or in developing a home health care plan.

### ***Home Health Care Agency***

A public or private agency or organization which:

1. Specializes in providing medical care and treatment in the home;
2. Is primarily engaged in providing skilled nursing services and other therapeutic services;
3. Is duly licensed by all appropriate authorities;
4. Has a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) , and establishes policies to govern the services provided;
5. Has a qualified practitioner or registered nurse (R.N.) providing full-time supervision of the services provide;
6. Maintains a complete medical record on each patient;
7. Has a full-time administrator; and
8. Is certified by Medicare.

## **Definitions – continued**

### ***Home Health Care Plan***

A written plan developed by a qualified practitioner or home health care agency describing the frequency and type of home health care to be provided. The home health care plan must be reviewed by a qualified practitioner at least once every two months, unless the qualified practitioner determines that a longer interval between reviews is sufficient. The home health care plan must include one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
2. Part-time or intermittent home health aide services provided under the supervision of a registered nurse (R.N.) or medical social worker, and which consists solely of caring for the patient;
3. Physical, respiratory, occupational or speech-language pathology therapy;
4. Medical supplies, drugs and medications prescribed by a qualified practitioner and laboratory services by or on behalf of a hospital to the extent such items would be covered under the plan if you had been confined to a hospital; or
5. Nutritional counseling provided under the supervision of a registered dietician.

### ***Hospice Care***

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

### ***Hospice Care Agency***

An agency which:

1. Has the primary purpose of providing hospice care to hospice patients;
2. Is licensed and operated according to the laws of the state in which it is located;
3. Has obtained any required certificate of need;
4. Provides 24-hour-a-day, seven-day-a-week service, supervised by a qualified practitioner;
5. Has a full-time coordinator;
6. Keeps written records of services provided to each patient;
7. Has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients;
8. Has a licensed social service coordinator;
9. Establishes policies for the provision of hospice care; assesses the patient's medical and social needs and develops a program to meet those needs;
10. Provides an ongoing quality assurance program;
11. Permits area medical personnel to use its services for their patients; and
12. Uses volunteers trained in care and services for non-medical needs.

## **Definitions - continued**

### ***Hospice Care Program***

A written plan of hospice care which is established and reviewed by a qualified practitioner and the hospice care agency, and describes palliative and supportive care to hospice patients and their immediate families.

### ***Hospice Facility***

A licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Has 24 hour a day nursing services, provided under the direction of a registered nurse (R.N.);
3. Has a full-time administrator;
4. Keeps medical records of each patient;
5. Has an ongoing quality assurance program; and
6. Has a qualified practitioner on call at all times.

### ***Hospital***

An institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a qualified practitioner and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where it is located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Hospital does **not** include an institution which is principally a rest home, nursing home, convalescent home or a home for the aged. Hospital does **not** include a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

### ***Immediate Family***

Your spouse, children, parents, grandparents, brothers and sisters and their spouses.

For hospice care only, your immediate family is your parent, spouse and dependent children.

### ***Injury***

Physical damage to your body caused by an external force and due, directly and independently of all other causes, to an accident.

## **Definitions – continued**

### ***Inpatient Treatment***

Treatment while confined as a registered bed patient in a hospital or qualified treatment facility.

### ***Late Applicant***

An employee who enrolls for coverage more than 31 days after they are eligible to be covered. A dependent who is enrolled for coverage more than 31 days (60 days for a newborn child or an adopted child) after they are eligible to be covered.

### ***Lifetime***

When used in reference to benefit maximums and limitations, the time you are covered under this plan, whether or not your coverage under the plan is continuous. In no circumstances does lifetime mean your life span.

### ***Medical Condition***

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

### ***Medically Necessary or Medical Necessity***

Health care services that a qualified practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's sickness, injury or disease, and (c) not primarily for the convenience of the patient, qualified practitioner, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's sickness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of qualified practitioners practicing in relevant clinical areas and any other relevant factors.

### ***Medicare***

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

### ***Outpatient Treatment***

Treatment received while not confined in a hospital or qualified treatment facility, including diagnostic laboratory examinations and psychological testing.

### ***PPO***

Preferred Provider Organization. If a provider has contracted with the PPO Network, they are a PPO Provider. PPO providers furnish services at a discounted rate to the plan. If a provider has not contracted with the PPO Network, they are a Non-PPO provider.

## **Definitions – continued**

### ***Plan***

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

### ***Plan Administrator or Trust***

WCA Group Health Trust.

### ***Plan Sponsor***

The plan sponsor of the plan is WCA Group Health Trust.

### ***Pre-Existing Condition***

A sickness or injury is pre-existing if you received treatment or drugs for it during the 180-day period immediately prior to your enrollment date. Treatment includes the initial diagnosis of the condition. Pre-existing conditions are covered after the end of a period of:

- a. 180 days from your enrollment date, if *you* are not a late applicant, or
- b. 545 days from your enrollment date, if you are a late applicant.

Pre-Existing conditions are covered after the end of a period of 18 month from your enrollment date.

### **Pre-Existing Condition Exceptions**

The exclusion will not apply:

- a. to any covered expense due to pregnancy,
- b. to a newborn dependent child. Such child must be enrolled for coverage within 60 days of the date of birth. A child that is provided coverage under the Mother's plan of benefits will be considered to be enrolled as of the date of birth,
- c. to a dependent child that is adopted or placed for adoption prior to their 18<sup>th</sup> birthday. Such child must be enrolled for coverage within 60 days of the adoption or placement, and
- d. to any condition that has not been diagnosed by a qualified practitioner, but has been indicated by genetic testing.

### **Pre-Existing Condition Credit**

Credit will be given under the pre-existing condition limitation, for all benefits, to the extent of your continuous coverage, without a lapse of more than 63 days. Coverage under any of the following plans is creditable: a. a group health plan; b. group, individual or other form of health insurance; c. Medicare (Part A, B or C); d. Medicaid; e. the Active Military Health Program or TRICARE; f. a medical program of the Indian Health Service or of a tribal organization; g. a State sponsored health benefits risk sharing pool; h. the Federal Employees Health Plan; i. a Peace Corp. Health Program; j. a public health plan that provides health coverage by insurance or other means including any plan established by the U.S. government, a State, a foreign country, or any political subdivision thereof; k. a State Children's Health Insurance Program (CHIPS).

## **Definition of Pre-Existing Condition – continued**

When you have coverage under a plan, you have the right to request written proof of that coverage at any time. When your coverage under a plan ends, you will be given written proof of coverage under that plan. It is your responsibility to provide this plan with this proof of coverage. If your prior plan did not provide you with proof of your coverage, this plan will assist you in providing proof of coverage by other means. Upon receiving proof of your prior coverage, you will be notified if there is any remaining pre-existing condition limit that may be applied.

### ***Protected Health Information***

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

### ***Qualified Practitioner***

A practitioner licensed to treat sickness or injury, who is providing services within the scope of that license. A practitioner who resides in your home or is a family member is not covered.

### ***Qualified Treatment Facility***

A duly licensed facility, institution or clinic, operating within the scope of its license, which provides treatment for a cause for which benefits are payable under the plan, including a facility established for treatment of psychological disorders, chemical dependence and alcoholism. These facilities do not include hospitals.

### ***Sickness***

1. A disease or disturbance in function or structure of your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of your body;
2. Muscle tiredness or soreness resulting from overexertion in a physical activity; or
3. Pregnancy.

### ***Total Disability or Totally Disabled***

Your inability due to sickness or injury to perform the substantial full-time duties of any job with the County. You also cannot work for wage or profit for anyone, including yourself.

For dependents, it means the inability due to sickness or Injury to carry on all of the normal activities of a healthy person of the same age and sex.

### ***Transitional Treatment***

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

## **Definitions – continued**

### ***Urgent Care Center*** (Walk-In Clinic)

A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. Urgent care center does not include a hospital or emergency room.

### ***Usual, Customary and Reasonable***

For Non-PPO Providers, the lesser of

1. The fee most often charged by the provider or
2. The maximum allowable fee as determined by the plan administrator by comparing similar services or procedures to a national data base adjusted to the locality where the services or procedures were performed.

In the case of a PPO Provider, it will mean the negotiated PPO discount rate for the service or procedure.

### ***You and Your***

You as the covered employee and any of your covered dependents, unless otherwise provided.

## **SECTION 3 ELIGIBILITY**

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## **ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

The Employee Coverage section applies to employees hired on or after the effective date of this plan. The Dependent Coverage section applies to dependents that are added on or after the effective date of this plan.

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

### **ANNUAL ENROLLMENT**

Each year you will be given the chance to choose among the benefit options the County offers. Once you have made elections for the year, they cannot be changed until the next annual enrollment period or change in status, except as stated under the Special Enrollment Rights.

The Annual Enrollment Period is held each year from during the months of February and March. Your elections will be effective the following April 1<sup>st</sup>. The County will notify you when the annual enrollment period is each year. (Note: Late applicants who come on this plan during the Annual Enrollment period will be considered late applicants for the purpose of the Pre-Existing Conditions limitations.)

### **EMPLOYEE ELIGIBILITY**

You are eligible for coverage under the plan if the following conditions are met:

1. You are an employee who meets the eligibility requirements of the County; and
2. You satisfy an eligibility period of 30 consecutive days of regular employment with the County.

You are eligible to be covered on the first day of the month after you complete the eligibility period. This is your eligibility date.

#### **Open Enrollment (Part-Time to Full-time) – Library Union Only**

If you transfer from an “over 600 hour part-time status” to full-time status, you may apply for coverage under this plan, provided the applicable eligibility period is satisfied. Your completed enrollment forms must be received by the plan administrator within 31 days after the effective date of the status change (e.g. the change to full-time status). Dental coverage will be effective on the first day of the month after the change to full-time status, provided the eligibility period is satisfied.

#### **Open Enrollment (Part-Time to Full-Time) – Court House Employees and Non-Represented Employees Only**

If you transfer from part-time status to full-time status, you may apply for coverage under the plan, provided the applicable eligibility period is satisfied. Your completed enrollment form must be received by the plan administrator within 31 days after the effective date of the status change (e.g. the change to full-time status). Dental coverage will be effective on the first day of the month after the change to full-time status, provided the eligibility period is satisfied.

## **EMPLOYEE EFFECTIVE DATE OF COVERAGE**

You must enroll on forms furnished and accepted by the plan administrator. Each employee's effective date of coverage is determined as follows:

1. If your completed enrollment forms are received by the plan administrator within 31 days of your eligibility date, your coverage is effective on your eligibility date.
2. If your completed forms are received by the plan administrator more than 31 days after your eligibility date, this is considered **late enrollment**. You will not be eligible for coverage until the next annual enrollment period or change in status, except as stated under the Special Enrollment Rights section of this Plan.

Coverage will begin at 12:01 AM, Standard Time, on your effective date. You must begin active work with the employer before coverage will be effective under the plan. (For County Board Supervisors, you must have taken the oath of office before coverage will be effective under the plan.)

## **DEPENDENT ELIGIBILITY**

Each dependent is eligible for coverage on the later of:

1. The date the employee is eligible for coverage, if the employee has dependents on that date;
2. The date of the covered employee's marriage for any dependents acquired on that date;
3. The date of birth of the covered person's natural born child;
4. The date a court order places a child in the employee's home. The child must be under the employee's legal guardianship;
5. The date a child is legally adopted; or
6. The date a valid court order is issued which, by federal law or plan provision, requires the plan to provide coverage.

Dependents of an employee may be covered only if the employee is also covered. Check with your employer on how to enroll for dependent coverage. Late enrollment may result in a delay of coverage.

If both the employee and a dependent are eligible for employee coverage under this plan, each covered expense is payable only once and each covered person is covered only once.

## **DEPENDENT EFFECTIVE DATE OF COVERAGE**

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

1. If a dependent's completed enrollment forms are received by the plan administrator within 31 days of the dependent's eligibility date, that dependent is covered on his or her eligibility date.
2. An eligible newborn of a covered person is covered for 60 continuous days from the moment of birth. If the newborn's enrollment forms are received by the plan administrator within 60 days of the date of birth, then the newborn will be a covered dependent effective the moment of birth.

## **Dependent Effective Date of Coverage - continued**

3. If the newborn's enrollment forms are received by the plan administrator more than 60 days and within one year after the date of birth and the covered employee makes all past due premium payments with interest at the rate of 5 ½% per year, than the newborn will be a covered dependent effective the moment of birth.
4. If you marry after your coverage is effective, you should apply for Family Coverage within 31 days of your marriage. If you do, your Family Coverage becomes effective on the date of the marriage.
5. If a dependent's completed enrollment forms are received by the plan administrator more than 31 days after the dependent's eligibility date, this is considered **late enrollment**. That dependent will not be eligible for coverage until the next annual enrollment period or change in status, except as stated under the Special Enrollment Rights section of this plan.

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

A dependent child who becomes an employee must apply for coverage as an employee to remain covered by the plan. The child will not be eligible as your dependent.

## **ANNUAL ENROLLMENT PERIOD**

Each year you will be given the chance to choose among the benefit options the County offers. Once you have made elections for the year, they cannot be changed until the next annual enrollment period or change in status, except as stated under the Special Enrollment Rights.

Completed enrollment forms must be received by the County before the end of the annual enrollment period. If your completed enrollment form is not received by that time, you will not be able to enter the plan until the next annual enrollment period or change in status, except as stated under the Special Enrollment Rights.

The County will notify you when the annual enrollment period is each year.

## **Changes In Status**

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

1. **Legal Marital Status.** Your marriage, divorce, legal separation, annulment or the death of your legal spouse;
2. **Number of Dependents.** An increase or decrease in the number of dependents you have due to birth, adoption, placement for adoption or the death of a dependent;
3. **Employment Status.** Any of the following events that change the employment status of you or your dependent, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;
4. **Dependent Status.** Your dependent satisfies or ceases to satisfy eligibility requirements for coverage due to an age limit, student status, or similar requirement of the plan;
5. **Residence.** Any change in residence for you or your dependent;

## **Annual Enrollment Period - continued**

6. **FMLA Leave Status.** At the time a leave under the FMLA begins the Employee may change elections to the extent allowed under the federal Family and Medical Leave Act;
7. **COBRA Continuation.** You or your dependent become eligible for and elect continuation coverage under the employer's group health plan as provided by COBRA or a similar State law;
8. **Judgment, Decree or Court Order.** An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires you or another individual to provide health coverage for your dependent child;
9. **Entitlement to Medicare or Medicaid.** A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for you or your dependent;
10. **HIPAA Special Enrollment Rights.** An event which qualifies as a special enrollment right under the Health Insurance Portability and Accountability Act;
11. **Significant Cost Increase.** Election changes are limited to increasing your election to cover the cost increase or changing the election to provide for a similar benefit offered by the employer;
12. **Significant Curtailment of Coverage.** An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;
13. **Addition or Elimination of a Benefit Option.** Election changes are limited to electing the new benefit option in the case of an added benefit option or electing a similar benefit in the case of the elimination of a benefit option;
14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of your spouse's, ex-spouse's or other dependent's employer. To qualify as a change in status under this plan the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If you have questions regarding whether an event qualifies as a change in status, the claims administrator will answer them.

## **RETIREE COVERAGE (UNION)**

Retiree Coverage applies after the Union "Extension of Benefits" provision of this plan is exhausted. (Such provision is outlined later in this section of the plan.) Retiree Coverage applies as outlined in your current employment contract or your current bargaining agreement.

NOTE: If you are Medicare eligible, claims must be submitted to Medicare first. After Medicare has processed your claim, the claim and the Medicare EOB should be submitted to this plan.

Marinette County will provide notification of Retiree Coverage to the claims administrator. Such notification must be made no later than 31 days after the date that the employee retired. If the claims administrator is not notified by the end of the 31-day period, COBRA continuation may be offered to any eligible person.

## **RETIREE COVERAGE (NON-UNION)**

Retiree Coverage applies after the Non-Union “Extension of Benefits” and Non-Union Survivorship Continuation provisions of this plan are exhausted. (Such provisions are outlined later in this section of the plan.) Retiree Coverage applies only if you meet the County’s eligibility requirements for Retiree Coverage.

NOTE: If you are Medicare eligible, claims must be submitted to Medicare first. After Medicare has processed your claim, the claim and the Medicare EOB should be submitted to this plan.

Marinette County will provide notification of Retiree Coverage to the claims administrator. Such notification must be made no later than 31 days after the date that the Employee retired. If the claims administrator is not notified by the end of the 31-day period, COBRA continuation may be offered to any eligible person.

## **SPECIAL ENROLLMENT RIGHTS**

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

### **Loss of Other Coverage**

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

1. Ends due to your exhaustion of the maximum COBRA period;
2. Ends due to your loss of eligibility, for any reason;
3. Ends benefits due to your reaching the lifetime maximum for all benefits; or
4. Ends employer contributions towards the cost of the other coverage;

Then a special enrollment event has occurred. At that time, an employee or dependent may be enrolled in this plan as follows:

1. When the employee has a loss of coverage, the employee and any dependent may enroll. The dependent does not have to have had a loss of coverage at that time to be enrolled;
2. When a dependent has a loss of coverage, that dependent and the employee may enroll, as well as other dependents. The employee and the other dependents do not have to have had a loss of coverage at that time to enroll.

*You* must enroll in this plan within 31 days of the date of a loss of other coverage to be a timely entrant to the plan. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this plan will not be effective until such proof is provided. Coverage under this plan will be effective on the day coverage under the other group plan ends.

If you apply more than 31 days after the date the other coverage ends, you will be late applicants under this plan.

## **Special Enrollment Rights – continued**

### **Marriage**

If you, as the employee, are now getting married, a special enrollment event will occur on the date of your marriage. At that time, you may enroll in this plan. Any dependents acquired on the date of your marriage may also be enrolled at this time, as well as any other dependents that were not previously covered under the plan.

You must enroll in this plan within 31 days of the date of marriage to be a timely entrant to the Plan. Coverage under the plan will be effective on the day of your marriage.

If you apply more than 31 days after the date of your marriage, it will be considered late enrollment under this plan.

### **Birth, Adoption or Placement for Adoption**

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

You must enroll in this plan within 31 days (60 days for a newborn child or an adopted child) of the date of birth, adoption or placement to be a timely entrant to the plan. Coverage under the plan will be effective on the date of such an event.

If you apply more than 31 days (60 days for a newborn child or an adopted child) after the date of such an event, it will be considered late enrollment under this plan.

### **MEDICAID/STATE CHILD HEALTH PLAN**

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

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

If you apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, you will be considered a late applicant under this plan.

### **Premium Assistance**

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

### **SPOUSAL TRANSFER PROVISION**

If both spouses are employees and each has taken single coverage under this plan, this plan permits your spouse to take coverage as your dependent at any time.

## **Spousal Transfer Provision – continued**

In addition, if both spouses are employees and eligible for coverage under this plan and your spouse previously waived coverage as an employee in favor of coverage as your dependent, this plan permits your spouse to take coverage as an employee under the plan and to enroll you and any other eligible dependents as dependents of your spouse when:

1. You and your spouse decide to transfer coverage under the plan from one spouse to the other;
2. Your spouse decides to take coverage as an employee for any reason; or
3. You terminate your coverage under the plan for any reason.

Your spouse must elect coverage under this plan within 30 days of the date your coverage ends to be a timely enrollment. Your spouse's coverage under this plan will be effective on the day your coverage ends.

If your spouse applies more than 31 days after the date your coverage ends, you will be late applicants under the plan.

## **BENEFIT CHANGES**

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

## **SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK**

### **Personal Leave of Absence**

If you are on an approved personal leave of absence, your coverage will remain in force for no longer than 365 days during the approved personal leave of absence. Your leave of absence must be approved by the County and a leave of absence provision must be specified in your collective bargaining agreement. Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The plan must remain in effect for this provision to apply. At the end of this 365-day period, COBRA continuation will be offered.

### **Medical Leave of Absence**

If you are on an approved medical leave of absence, your coverage will remain in force for no longer than 365 days during the approved medical leave of absence. Your leave of absence must be approved by the County and a medical leave of absence provision must be specified in your collective bargaining agreement. Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The plan must remain in effect for this provision to apply. At the end of this 365-day period, COBRA continuation will be offered.

## **REINSTATEMENT OF COVERAGE**

Note: Reinstatement does not apply if you voluntarily terminated your employment with the County.

If you return to work within 365 days of a termination of coverage, your coverage will be effective on the day you return to work. The eligibility period will be waived with respect to the reinstatement of your coverage. You must apply for reinstatement within 31 days from the date that you returned to work.

## **Reinstatement of Coverage - continued**

### **Reinstatement for Permanent Seasonal Employees**

Note: Reinstatement does not apply if you voluntarily terminated your employment with the County

If you return to work within 365 days of a termination of coverage, your coverage will be effective on the day you return to work. The eligibility period will be waived with respect to the reinstatement of your coverage. You must apply for reinstatement within 31 days from the date that you returned to work.

## **EXTENSION OF BENEFITS**

### **Union Employees**

Benefits under this plan may be extended upon your retirement, resignation or dismissal from employment with the County. Extension of Benefits applies to covered Union Employees and their covered, eligible dependents, as specified in your current Union bargaining agreement. Contact the County for more details about the Extension of Benefits. At the end of this Extension of Benefits, Retiree Coverage may apply, subject to the conditions stated in your current bargaining agreement. COBRA continuation will be offered to any eligible person.

### **Non-Union**

Benefits under this plan may be extended upon your retirement, resignation or dismissal from employment with the County. Extension of Benefits applies to covered Non-Union Employees and their covered, eligible dependents, as specified in the County's current policy and procedures manual. Contact the County for more details about the Extension of Benefits. At the end of this Extension of Benefits Retiree Coverage may apply, subject to the conditions stated in your current bargaining agreement. COBRA continuation will be offered to any eligible person.

### **Permanent/Seasonal Employees**

Benefits under this plan may be extended at the end of your seasonal employment. Extension of Benefits applies to covered permanent seasonal employees. Coverage may be extended for no longer than 365 days from the date that your permanent seasonal employment ends. If you elect this Extension of Benefits at the conclusion of your seasonal employment, coverage will continue until the earliest of the following:

1. The date the you are no longer identified as a Permanent Seasonal Employee in the books and records of the employer and you are terminated as a Permanent Seasonal Employee;
2. The date you do not return to permanent seasonal employment within the time period specified above;
3. The date you do not return to active, permanent seasonal employment when required by the employer; or
4. The date coverage under the plan is terminated during the 365-day period.

All other provisions and limitations as stated in the plan will apply to this extension of benefits. COBRA Continuation will be offered at the end of this Extension of Benefits period. The plan must remain in effect for this provision to apply.

## **SURVIVORSHIP CONTINUATION – WPPA UNION**

### **Employees Who Die in the Line of Duty**

If you have dependent coverage in force on the date that you die in the line of duty, coverage under this plan will continue for your covered dependents until employee would have been eligible for Medicare, provided the dependents continue to meet the eligibility requirements of this plan. Upon termination of this extended coverage, the surviving dependent spouse and dependent children may be eligible to continue coverage under this plan indefinitely. The surviving dependents must pay the required plan contribution amounts.

### **Employees Who are Disabled in the Line of Duty**

If an active, covered WPPA Union Employee becomes permanently disabled due to a sickness or injury that occurs in the line of duty, the employee's covered dependent spouse and covered eligible dependent children may continue coverage under this plan until such employee would have been eligible for Medicare. Such dependents (spouse and children) must continue to meet the eligibility requirements of this plan. Upon termination of this extended coverage, the dependent spouse and dependent children may be eligible to continue coverage under this plan indefinitely. The surviving dependents must pay the required plan contribution amounts.

## **SURVIVORSHIP CONTINUATION – NON UNION**

If an active, non-union employee dies while covered under this plan, coverage under this plan will continue for your covered dependents for the length of time specified by the County. Such dependents must continue to meet this plan's definition of dependent. Upon termination of this extended coverage, the surviving dependents may be eligible for COBRA Continuation.

## **TERMINATION OF COVERAGE**

Coverage terminates on the earliest of the following:

1. The date the plan terminates;
2. For any benefit, the date the benefit is removed from the plan;
3. The end of the period for which any required employee or County contribution was due and not paid;
4. The date you enter the full-time military, naval or air service of any country;
5. Either the end of the month in which you fail to be in an eligible class of persons according to the eligibility requirements of the County, or the end of the month following the month in which you fail to be in an eligible class of persons according to the eligibility requirements of the County. (Contact the County to determine the termination date.);
6. For all employees, either the end of the month in which termination of employment with the County occurs or the end of the month following the month in which termination of employment with the County occurs or, if earlier, either the end of the month in which you are no longer Actively at Work, as defined in this plan, or the end of the month following the month in which you are no longer Actively at Work as defined in this plan. (Contact the County to determine the termination date.)
7. For all Employees, either the end of the month in which your retirement occurs or the end of the month following the month in which your retirement occurs, unless you are eligible for, and elect, Retiree Coverage. (Contact the employer to determine the termination date.)
8. For a dependent, the date the employee's coverage terminates;;
9. For a dependent, either the end of the month in which that dependent no longer meets this plan's definition of dependent, or the end of the month following the month in which that dependent no longer meets this plan's definition of dependent. (Contact the employer to determine the termination date.);
10. For a dependent, the date that dependent enters the full-time military, naval or air service of any country;
11. The date you request termination of coverage to be effective for yourself and/or your dependents; or
12. The date you die. (Refer to the Survivorship Continuation provisions for information about certain employees who have dependent coverage in force on the day of the employee's death.)

### **Important Notice for Active Employees and Spouses Age 65 and Over**

The plan cannot terminate your coverage due to age or Medicare status. An active employee that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this plan, in which case Medicare benefits would be secondary to this plan; or
2. End coverage under this plan, in which case Medicare would be the only coverage available to you.

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

Contact the County for further information.

## **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

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

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

### **EMPLOYEE ELIGIBILITY**

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

1. The employee has been employed with the employer for a total of at least 12 months;
2. The employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
3. The employee is employed at a worksite that employs at least 50 employees.

### **TYPES OF LEAVE**

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

#### **Family and Medical Leave**

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

1. The birth of the employee's child;
2. The placement of a child with the employee for adoption. The placement of a child with the employee for foster care;
3. The employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;
4. The employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or
5. Any qualifying necessity that results from the employee's spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

#### **Military Family Leave**

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

## **FMLA - continued**

### **Maximum Leave Period**

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

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

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;
2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or
3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

### **Termination Before the Maximum Leave Period**

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

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

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

### **Recovery of Plan Contributions**

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

## **REINSTATEMENT OF COVERAGE UPON RETURN TO WORK**

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

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

## **DEFINITIONS**

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

**Serious Health Condition** is any sickness, injury, impairment or physical or mental condition that involves:

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

## **FMLA - continued**

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

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

**Spouse** is your lawful husband or wife.

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

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

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

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

# **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

## **CONTINUATION OF COVERAGE DURING MILITARY LEAVE**

The law requires that coverage under this plan be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the plan to similar active employees. This means that when coverage is changed for similar active employees it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the employee contribution required for active employees;
2. For leaves of 31 days or more, up to 102% of the full contribution.

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

Coverage provided due to this Act will reduce any coverage required by COBRA.

### **Maximum Period of Coverage during Military Leave**

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

1. The date you fail to return to employment with the employer after completion of your leave. Employees must return to employment within:
  - a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
  - b. 14 days of completing military service, for leaves of 31 to 180 days,
  - c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.

## **REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE**

The law requires that coverage be reinstated upon your return to work. Reinstatement will apply whether coverage under the plan was maintained during the leave or not. To be eligible for reinstatement you must be honorably discharged from the military service and return to work within:

1. The first, full business day after your military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days after your military service ends, for leaves of 31 to 180 days;
3. 90 days after your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if your military service: causes a sickness or injury; or worsens a sickness or injury. Your failure to return within the times stated must be due to such a sickness or injury. In that case, you may take up to a period of two years to return to work. If for reasons beyond your control you cannot return to work within two years, you must return as soon as is reasonably possible.

**USERRA - continued**

On reinstatement, all provisions and limits of the plan will apply to the extent that they would have had you not taken leave. The eligibility period will be waived. The pre-existing condition limit will be credited as if you had been continually covered under the plan.

This does not waive the plan's limits on sickness or injury: caused by your military service; or worsened by your military service. The Secretary of Veterans Affairs will determine if your military service caused or worsened a sickness or injury.

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

## **CONTINUATION OF BENEFITS**

### **THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)**

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

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

#### **Employee Rights to COBRA**

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

1. A reduction in the employee's hours of work; or
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part.

#### **Spouse Rights to COBRA**

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

1. A reduction in the employee's hours of work;
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part;
3. The death of the employee;
4. The end of the spouse's marriage to the employee. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The employee becoming entitled to Medicare.

#### **Dependent Child Rights to COBRA**

The dependent child of an employee that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the employee's hours of work;
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part;
3. The death of the employee;
4. The end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

COBRA – continued

5. The employee becoming entitled to Medicare; or
6. The child ceasing to be considered a dependent child as defined in this plan.

### **Electing COBRA**

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

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

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

### **Retiree Coverage (if provided)**

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

### **Notices and Election of Coverage**

Under the law, you must inform the plan administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. You must also inform the plan administrator within 60 days of a child no longer meeting the plan's definition of dependent. The employer must notify the plan administrator of: the employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The employer must also notify the plan administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the plan administrator will notify you that you have the right to elect COBRA. If the employer and the plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law you must elect COBRA within 60 days from the later of: the date you would lose coverage or cost would increase due to the qualifying event; or the date notice of your right to COBRA and the election form are sent.

The plan administrator must provide you with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

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

## **COBRA - Continued**

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

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the plan administrator.

### **Maximum Period of Continuation of Coverage**

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

1. 18 months, if due to the employee's termination of employment. Termination must be for reasons other than gross misconduct on the employee's part;
2. 18 months, if due to the employee's reduction in work hours;
3. 36 months, if due to the death of the employee;
4. 36 months, if due to the end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. 36 months, if due to the employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;
6. 36 months, if due to your ceasing to be a dependent child as defined in the plan; or
7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered dependent may elect COBRA for an additional 36 months from that date.

If you or a dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if you or a dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the plan administrator within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, you will not be eligible for the extended period. If it is determined that you are no longer disabled, you must notify the plan administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

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

## COBRA – continued

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

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

### **Termination Before the End of the Maximum Coverage Period**

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

1. The employer no longer provides a group benefit plan to any of its employees;
2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;
3. You obtain another group plan after the date you elect COBRA. This will not apply if that group plan has a pre-existing condition exclusion or limit that applies to you. If such limit or exclusion has been met by a credit from your previous coverage, this provision will apply. If your new plan does have a pre-existing condition exclusion or limit that applies to you, then COBRA will end on the earlier of: the date that exclusion or limit no longer applies to you; or the end of the maximum coverage period;
4. You become entitled to Medicare after the date you elect COBRA;
5. There has been a final determination that you are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

### **Additional Election Period due to The Trade Act of 2002**

If you did not elect COBRA during the election period described above, another 60 day period may be presented for you to elect COBRA. If your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and you are determined to be TAA eligible during the six month period following your loss of coverage, you will have an additional period in which to elect COBRA. This election period will begin the first of the month in which you become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following your loss of coverage due to a TAA event.

If you elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which you became TAA eligible. COBRA will not be provided for the period of time between your loss of coverage and the first of the month in which you became TAA eligible. However, that time will not be counted as a lapse in coverage for purposes of determining if the plan's pre-existing condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date you lost coverage under the plan, not the date COBRA is effective. If you do not elect COBRA within this period, COBRA will not be available again.

COBRA – continued

If you elect COBRA, it is your duty to pay all of the monthly payments directly to the plan administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 65% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If *you* have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

ARRA made several amendments to the Trade Act of 2002, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered Employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

### **Procedures for Providing Notice to the Plan**

In order to maintain your rights under COBRA, you are required to provide the plan with notice of certain events, as described above. The plan will consider your obligation to provide notice satisfied if you provide written notice to the plan administrator that includes:

1. The employee's name and social security number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where you can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the plan administrator's address shown in this plan. Your notice will not satisfy your obligation if it is not provided within the time frame stated above for that notice.

### **Other Information**

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

To protect your rights under COBRA, you should notify the plan administrator of any changes that affect your coverage. Such changes include a change for you or a family member in marital status; address; or other insurance coverage. When providing any notice to the plan, a copy should be maintained for your own records. When COBRA ends, you will have the right to Conversion coverage, if offered by this plan.

### **AMERICAN RECOVERY AND REINVESTMENT ACT**

**Note: This provision will automatically terminate on December 31, 2011, and benefits outlined will no longer be available without further Plan amendment.**

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act of 2010 ("Defense Act"), the Temporary Extension Act of 2010 ("TEA"), the Continuing Extension Act of 2010 and any future applicable legislation, reduces the COBRA premium in some cases. If a covered person experienced a Loss of Coverage due to involuntary termination by the employer during the period that begins with September 1, 2008 and ends with May 31, 2010, the covered person may be eligible for the temporary premium reduction for up to 15 months.

Medical - Effective January 1, 2010

## **COBRA - continued**

### **ELIGIBLE INDIVIDUALS**

Covered persons and their dependents who experienced a Loss of Coverage under the plan due to an involuntary termination of employment between September 1, 2008 and May 31, 2010 or is an individual who experiences a qualifying event that is a reduction of hours occurring at any time from September 1, 2008 and May 31, 2010, which is followed by an involuntary termination of employment on or after March 2, 2010 through May 31, 2010 and as a result, fit the definition of qualified beneficiary under COBRA are eligible. These individuals may also be referred to as Assistance Eligible Individuals (AEIs).

Some AEIs will have declined COBRA prior to passage of the law or elected COBRA but then dropped coverage prior to passage of the law. These AEIs will have a second opportunity to elect COBRA coverage and take advantage of the premium subsidy (reduced premium).

Some AEIs who have exhausted their nine month subsidy period prior to December 19, 2009 and who failed to pay the premium during the transition period may be eligible to retroactively reinstate coverage provided that they pay the reduced premium for such coverage within 60 days of the date of the enactment (in which case the due date would be February 17, 2010) or if later, 30 days after the date the notice is provided. The transition period is any period of coverage that begins prior to December 19, 2009 and is subject to the extension.

In addition, any AEI who exhausted their nine month subsidy period prior to the date of enactment of the "Defense Act", and then subsequently paid the full premium during the transition period (the period of coverage that begins prior to December 19, 2009) are entitled to a refund or credit as prescribed by the original ARRA legislation.

An AEI that is eligible for the subsidy as a result of a reduction of hours that is followed by an involuntary termination of employment will have his or her maximum COBRA coverage measured from the date of the reduction in hours. This means that upon the later involuntary termination of employment, the individual can elect COBRA coverage only for the remainder of the original COBRA coverage period which began upon the reduction of hours of employment. Please refer to your COBRA election form for additional information regarding your rights to COBRA.

Assistance Eligible Individuals must not be eligible for coverage under any other group health plan (other than certain limited plans). This includes eligibility for coverage under a spouse's employer's plan or Medicare. Failure to notify the plan of eligibility under any other group health plan can result in significant penalties.

The subsidy will be phased out starting with taxpayers whose modified adjusted gross income exceeds \$125,000 (\$250,000 in the case of a joint return). This means a percentage of the subsidy will be recaptured in the federal income taxes imposed on individuals making more than \$125,000 (\$250,000 in the case of a joint return). Higher income individuals (\$145,000 (\$290,000 in the case of a joint return) can make an election to waive the subsidy in the manner and form set forth by the Secretary of the Treasury.

### **AMOUNT AND LENGTH OF SUBSIDY**

Assistance Eligible Individuals will be responsible for only 35% of the amount of their COBRA premium. That means a qualified beneficiary whose normal full COBRA premium would be \$500 per month would be responsible for paying only \$175 per month for the qualifying time period.

The subsidy period ends at the earliest following date:

- Fifteen months after the date the individual becomes eligible for the subsidy;

## **COBRA – continued**

- The qualified beneficiary becomes eligible for coverage under any other group health plan (other than certain limited plans) or becomes eligible for Medicare. This also includes eligibility for coverage under a spouse's employer's plan. The qualified beneficiary must notify the administrator in writing of such eligibility as set forth by the Department of Labor (DOL). Failure of the qualified beneficiary to notify the administrator may result in a penalty of 110% of the premium reduction provided after termination.
- The qualified beneficiary's maximum period of continuation coverage required under the applicable COBRA continuation coverage provision is met. Note that for those qualified beneficiaries receiving a second opportunity to elect coverage, the maximum COBRA continuation coverage period runs from the original qualifying event.

## **ELECTING THE SUBSIDY**

If you have a qualifying event between September 1, 2008 and May 31, 2010, your COBRA Administrator will send you a formal notification of your COBRA rights under the American Recovery and Reinvestment Act, as amended. The notification will include the necessary forms and instructions on how to elect to receive the subsidy as applicable.

If it is determined that you are not an AEI, and you disagree with this determination, you may appeal this determination with the Department of Labor (DOL) in the manner and form specified by them. Please see <http://www.dol.gov/ebsa/subsidydenialreview.html>. State and local government Employees should contact HHS-CMS at [www.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

## **ELECTING DIFFERENT COVERAGE**

If your plan offers a lower cost option, Assistance Eligible Individuals have the option to elect enrollment in the less expensive coverage than what the individual was enrolled in at the time the qualifying event occurred, if such coverage is generally available to current employees. If the employer offers this option, the notification that you will receive in the next few weeks will include information on the plans that are available and explain the procedure for enrolling in different coverage. If an AEI chooses to enroll in different coverage, such coverage shall be treated as COBRA continuation coverage. In order for the qualified beneficiary to be eligible to elect different coverage than what they were enrolled in at the time of the qualifying event, all of the following must apply:

1. The premium for different coverage cannot be more than the premium for the coverage the individual was enrolled in when the qualifying event occurred;
2. The different coverage must also be offered to active employees at the time the election is made;
3. The different coverage cannot be coverage that provides only:
  - a. dental, vision, counseling or referral services (or a combination of such services),
  - b. a flexible spending account,
  - c. coverage for services or treatments furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or combination of such care).

This election must be made in writing and not more than 90 days after the date of your formal COBRA notification.

If you have any questions about your rights to COBRA continuation coverage, you should contact your COBRA administrator.

Medical - Effective January 1, 2010

## **INDIVIDUAL MEDICAL CONVERSION PRIVILEGE**

If an individual conversion plan is available from the Trust, the plan administrator will, during the 180-day period before the applicable end of continuation coverage, offer a covered person who is covered until the end of the maximum period of continuation coverage the option of enrollment under a conversion health plan.

If an individual conversion health plan is not available from the Trust, you may continue group coverage until:

1. The individual on continuation coverage establishes residence outside this state that the employer is located in;
2. The individual on continuation coverage fails to make a timely payment of a required premium amount;
3. For an individual on continuation coverage who is eligible for continued coverage as the former spouse of a covered person and who would otherwise terminate coverage because of divorce or annulment, the covered person through whom the former spouse originally obtained coverage is no longer eligible for coverage by the plan; or
4. The individual on continuation coverage becomes eligible for similar coverage under another plan.

The conversion carrier sets the type of coverage and benefits that will be offered. Benefits provided under conversion may differ from those of this plan.

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## **SECTION 4 GENERAL PLAN INFORMATION**

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## **COORDINATION OF BENEFITS**

### **Benefits Subject to This Provision**

This plan's benefits are coordinated with benefits provided by other plans that cover you. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this plan. This provision will apply whether or not you file a claim under any other plan that covers you.

### **Effect on Benefits**

Total reimbursement from all plans will not exceed 100% of the total covered expenses under this plan.

### **Definitions**

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

1. Group or franchise insurance coverage, whether insured or self-funded;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the covered person's membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

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

### **How Coordination of Benefits Works**

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

When a plan provides benefits in the form of services rather than cash payments, the usual, customary and reasonable value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

### **Order of Benefit Determination**

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.
2. The plan that covers the person as an employee will be primary.

## **Coordination of Benefits - continued**

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary. (If the other plan does not have the birthday rule, but has a rule which coordinates benefits based on gender and the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.)
4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
  - a. the plan of a parent who has primary physical placement will be primary,
  - b. the plan of a step-parent that has primary physical placement will pay benefits next,
  - c. the plan of a parent who does not have primary physical placement will pay benefits next, and
  - d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

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

6. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:
  - a. the plan of a parent who has primary physical placement will pay the benefits first,
  - b. the plan of a parent who does not have primary physical placement will pay benefits next,
  - c. the plan of a grandparent whose child has primary physical placement will pay benefits next,
  - d. the plan of a grandparent whose child does not have primary physical placement will pay benefits next.

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

7. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee.
8. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

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

If a plan other than this Plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

## **Coordination of Benefits between Medical and Dental Plans**

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

## **Coordination of Benefits – continued**

### **Coordination of Benefits with Medicare**

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Your benefits under this plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations.

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

# **RECOVERY RIGHTS**

## **GENERAL RECOVERY RIGHTS PROVISIONS**

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

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

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

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

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

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the plan. It also includes any medical, dental or loss of time expense that may be payable by the plan in the future.
2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; you or your covered dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of your benefits under this plan.

#### **Right of Subrogation**

If, after payments have been made under this plan, you have a right to recover damages from a responsible or liable party, the plan shall be subrogated to that right to recover. The plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the plan.

## **Recovery Rights - continued**

### **Right of Reimbursement**

If benefits are paid under this plan and you recover from a responsible or liable party by settlement, judgment or otherwise, the plan has a right to recover from you. Recovery will be in an amount equal to the amount of plan assets paid on your behalf. The plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of plan assets that are paid or payable for any health care expenses under the plan.

### **Excess Coverage Provision**

Benefits are not payable for an injury or sickness if there is any responsible or liable party providing coverage for health care expenses you incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the plan may make payments on your behalf for covered expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the plan and will be considered an advancement of plan assets to you.

This plan does not provide benefits or may reduce benefits for any present or future covered expenses that you have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the plan.

### **Workers' Compensation**

This plan excludes coverage for any injury or sickness that is eligible for benefits under workers' compensation. If benefits are paid by the plan and you receive workers' compensation for the same incident, the plan has the right to recover. That right is described in this section. The plan reserves its right to exercise its recovery rights against you even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the injury or sickness was sustained in the course of or resulted from your employment;
3. The amount of workers' compensation due to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
4. The health care expense is specifically excluded from the workers compensation settlement or compromise.

## **GENERAL PROVISIONS**

The following provisions are to protect Your legal rights and the legal rights of the Plan.

### **ALTERNATE RECIPIENTS**

If a court order requires a Covered Person to provide health care coverage for a Dependent child, coverage must be provided to the child. Coverage may not be subject to Plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of Dependents are also waived for that child. If a Covered Person does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an employee under the plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the plan. They must be provided with a copy of the plan's Summary Plan Description (SPD). Any payments made by the plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

A court order will not entitle the child to any benefits or coverage not already offered by the plan.

### **AMENDMENTS TO OR TERMINATION OF THE PLAN**

The plan's benefits may be amended by the County at any time. The plan may be terminated by the County at any time. Any changes to the plan will be communicated immediately by the County to the persons covered under the plan.

If the plan is terminated, the rights of the covered persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. Plan assets will be allocated to the exclusive benefit of the covered persons. Any taxes and expenses of the plan may be paid from the plan assets.

### **ASSIGNMENT**

Any assignment will only be applied if the provider will refund any payments made in error. The plan does not attest to the legal validity or effect of any assignment.

### **CLAIM REVIEW PROCEDURE**

The rules stated in this section shall be followed by all persons and entities seeking review of any decision as to eligibility for benefits or the amount of benefits paid. These rules shall be the exclusive remedy for any such decision, except as otherwise required by applicable law.

#### **Request for Review**

Any participating employee or beneficiary who has been affected by a decision to deny a claim for benefits, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after the mailing of a written notice of the denial of the claim or of the amount of the benefits to be paid. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

Medical - Effective January 1, 2010

## **Claim Review Procedure Provision - continued**

### **Review**

On timely receipt of a request for review, the Claims Review Committee shall schedule a review within **sixty (60) days** of receipt of the request. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how you may participate in the telephone conference, if you wish. At the telephone conference, you may add any information you wish. However, you may not remain on the telephone conference when the Claims Review Committee deliberates and decides your claims.

### **Decision**

The Claims Review Committee shall issue a written decision within **ten (10) days** after the end of the review, affirming, modifying or setting aside the previous decision or action. The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

To submit a request of claim review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee  
WCA Group Health Trust  
22 East Mifflin Street, Suite 900  
Madison, WI 53703

## **CLERICAL ERROR**

A clerical error by the County, the plan administrator or the claims administrator will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

## **CONFORMITY WITH APPLICABLE LAWS**

If any part of this plan is contrary to any applicable law, that provision is amended to conform with such law and the rest of the plan remains in effect.

## **CONTRIBUTIONS TO THE PLAN**

The plan is funded by contributions from the employer and the covered employee.

Any funds contributed by the employees are applied to the expenses of the plan as soon as is reasonably possible. Any excess funds are used to pay claims. The employer sets the amount of the employee contribution. The employer reserves the right to modify such contributions. All employee contributions are on a non-discriminatory basis.

## **COOPERATION**

You must cooperate with the plan administrator, claims administrator, and or any person designated by the plan administrator in connection with this plan.

## **FAILURE TO ENFORCE PLAN PROVISIONS**

No failure to enforce any provision of the plan will affect the right, thereafter, to enforce such provision or affect the right to enforce any other provisions of the plan.

Medical - Effective January 1, 2010

## **General Provisions – continued**

### **FREE CHOICE OF PROVIDER**

The covered person has a free choice of any legally licensed provider. The plan will not interfere with the provider/patient relationship.

### **HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT**

This plan is not financed or administered by an insurance company and benefits are not guaranteed by a contract of insurance.

If you have any questions about your rights under the Health Insurance Portability and Accountability Act of 1996, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 2000 Constitution Avenue, N.W., Washington D.C. 20210.

### **LEGAL ACTIONS**

You cannot bring an action to compel payment under the Plan until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the Plan has denied full payment of Your claims, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

### **PAYMENT OF CLAIMS**

Any payment made in good faith will fully discharge the Plan to the extent of such payment. If benefit payments have been made under any other plan which should have been made by this plan, the plan administrator may reimburse such plan. Any payments made in good faith will fully discharge the plan's obligations to you to the extent of such payment.

Benefits will be paid directly to the provider of services, unless you direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of you or your covered dependent, upon death, will be paid at the plan administrator's option to any one or more of the following: your estate; your spouse; your dependent children; your parents; or your brothers and sisters.

### **PHYSICAL EXAMINATION**

The plan administrator, at its own expense, has the right to have you examined as often as it deems reasonably necessary while a claim is pending.

### **PRIVACY OF PROTECTED HEALTH INFORMATION**

#### **1. Plan Sponsor's Certification of Compliance**

Neither the plan nor any business associate servicing the plan will disclose plan participants' Protected Health Information to the plan sponsor unless the plan sponsor certifies that the plan document has been amended to incorporate this section and agrees to abide by this section.

Medical - Effective January 1, 2010

## **Privacy of Protected Health Information - continued**

### **2. Purpose of Disclosure to Plan Sponsor**

- a. The plan and any business associate servicing the plan will disclose plan participants' Protected Health Information to the plan sponsor only to permit the plan sponsor to carry out plan administration functions for the plan not inconsistent with the requirements of Wisconsin law and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Such disclosure will include disclosure for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in the plan's Notice of Privacy Practices. Any disclosure to and use by the plan sponsor of plan participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.
- b. Neither the plan nor any business associate servicing the plan will disclose plan participants' Protected Health Information to the plan sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the plan participants.

Neither the plan nor any business associate servicing the plan will disclose plan participants' Protected Health Information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

### **3. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information**

- a. The plan sponsor will neither use nor further disclose plan participants' Protected Health Information, except as permitted or required by the plan document, as amended, or as required by law.
- b. The plan sponsor will ensure that any agent, including any subcontractor, to which it provides plan participants' Protected Health Information agrees to the restrictions and conditions of the plan document, including this section, with respect to plan participants' Protected Health Information.
- c. The plan sponsor will not use or disclose plan participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
- d. The plan sponsor will report to the plan any use or disclosure of plan participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
- e. The plan sponsor will make Protected Health Information available to the plan or to the plan participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524 and any applicable Wisconsin law.
- f. The plan sponsor will make plan participants' Protected Health Information available for amendment, and will on notice amend plan participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526 and any applicable Wisconsin law.
- g. The plan sponsor will track disclosures it may make of plan participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528 and any applicable Wisconsin law.

## **Privacy of Protected Health Information - continued**

- h. The plan sponsor will make its internal practices, books and records relating to its use and disclosure of plan participants' Protected Health Information available to the plan and to the U.S. Department of Health and Human Services to determine the plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E ("Privacy of Individually Identifiable Health Information").
- i. The plan sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all plan participant Protected Health Information, in whatever form or medium, received from the plan or any business associate servicing the plan, including all copies thereof and all data, compilations, or other works derived there from that allow identification of any participant who is the subject of the Protected Health Information, when the plan participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all plan participant Protected Health Information, the plan sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any plan participant Protected Health Information that cannot feasibly be return or destroyed to those purposes that make the return or destruction of the information feasible.
- j. The plan sponsor will ensure that the required adequate separation, described in detail in paragraph 4, below, is established and maintained.

### **4. Adequate Separation Between the Plan Sponsor and the Plan**

- a. The following persons under the control of the plan sponsor may be given access to plan participants' Protected Health Information received from the plan or a business associate servicing the plan:

Employees of Wisconsin Counties Association who hold the positions of Director of Insurance Services, Director of Administration and Finance, Insurance Services Administrator, Operations Manager, Executive Administrative Assistant, Administrative Assistant.

All employees of all entities with whom the plan has entered into business associate agreements to the extent those employees perform tasks for or on behalf of the plan and/or the plan sponsor.

This list includes every employee or class or employees or other persons under the control of the plan sponsor who may receive plan participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business. The employees or other persons above shall also be given access to plan participants' Protected Health Information for the purpose of rendering final claim appeal determinations.

- b. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will have access to plan participants' Protected Health Information only to perform the plan administration functions that the plan sponsor provides for the plan.

## **Privacy of Protected Health Information - continued**

- c. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the plan sponsor, for any use or disclosure of plan participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan sponsor will promptly report such breach, violation or noncompliance to the plan, as required by paragraph 3(d) of this section, and will cooperate with the plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

### **5. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

- a. The plan may disclose Summary Health Information (SHI) to the plan sponsor, if the plan sponsor requests the Summary Health Information (SHI) for the purpose of:
  1. Obtaining premium bids for the health coverage offered under the plan; or
  2. Modifying, amending or terminating the plan.

Summary Health Information (SHI) includes aggregated claims history, claims expenses or types of claims experienced by enrollees in the plan. Although this information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the SHI as belonging to a particular participant.

- b. The plan may disclose enrollment and disenrollment information to the plan sponsor.

## **PROOF OF LOSS**

You must provide the plan with written proof of your claim. Proof should be provided within six months after the date the claim was incurred. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless you were legally incapacitated during the period, any claim received by the plan more than 16 months after the date the claim was incurred will not be covered under the plan.

If the plan is terminated, written proof of any claims incurred prior to the termination must be given to the plan within 90 days of its termination. Any claim received by the plan more than 90 days after it is terminated will not be covered under the plan.

## **PROTECTION AGAINST CREDITORS**

Benefit payments under the plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the plan administrator finds that such an attempt has been made, it, at its sole discretion, may terminate your interest in the payments. The plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the covered person. Such payment will fully discharge the plan to the extent of the payment.

## **General Provisions - continued**

### **REPRESENTATIONS**

All representations by a covered person are material and relied upon in providing coverage under the plan.

### **RIGHT TO NECESSARY INFORMATION**

The claims administrator has the right to decide which facts it needs to apply and coordinate these provisions with other plans. It may get needed facts from or give them to any other organization or person without consent of the insured, but only as needed to apply these provisions. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give the claims administrator any facts it needs to pay the claim.

### **SECURITY**

The WCA Group Health Trust, who is the sponsor of this plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Trust certifies to the plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;
2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Trust under this provision;
3. Report to the plan any security incident that the Trust becomes aware of; and
4. Apply reasonable and appropriate security measures to maintain adequate separation between the plan and itself.

### **TERMINATION OF THE PLAN**

If the plan is terminated, the rights of the covered persons to benefits are limited to claims incurred and payable by the plan before the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of covered persons, except that any taxes and administration expenses may be paid from the plan assets.

### **TIME OF CLAIM DETERMINATION**

Benefits due under the plan will be paid as soon as reasonably possible upon receipt of written proof of loss.





AMENDMENT #1

WCA Group Health Trust – Marinette County (Medical)  
Group Number: WCA0038

**BENEFIT PLAN AMENDMENT**

**IT IS UNDERSTOOD AND AGREED THAT:**

**THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2011.**

**On page 1-3, the “Medical Plan - Lifetime Maximum” section of the Schedule of Benefits is amended to read as follows:**

**Medical Plan - Lifetime Maximum: Unlimited.**

**WCA Group Health Trust – Marinette County (Medical)  
Amendment #1**

On page 1-6, the “Wellness Benefit” section of the Schedule of Benefits” is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	<p><b>PPO:</b> 100%, deductible and coinsurance waived</p> <p><b>Non-PPO:</b> 100%, deductible and coinsurance waived</p> <p><b>Mammograms, Pap Smears, PSA Tests &amp; Colonoscopies:</b> <b><u>1<sup>st</sup> per calendar year:</u></b> 100%, deductible and coinsurance waived (for PPO and Non-PPO providers)</p> <p><b>Additional in the same calendar year:</b> <b><u>Routine:</u></b> <b>PPO:</b> 100%, deductible and coinsurance waived</p> <p><b>Non-PPO:</b> Subject to the deductible and coinsurance</p> <p><b><u>Non-Routine</u></b> Subject to the deductible and coinsurance</p>	<p>Benefits include routine physical exams, well child care, routine x-ray and laboratory tests, routine mammograms, routine pap smears, routine PSA tests, routine colonoscopies, routine exams for school, sports and camps, third-party exams and treatments and blood lead tests for a dependent under age six years exams.</p> <p><u>Refer to the text for details and limits.</u></p> <p><b>X-rays and Lab Tests:</b> All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-14

On page 1-7, the “Emergency Room Benefit” section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p><b>Those who retired prior to 9/15/2009:</b>  <b>PPO:</b> Subject to the PPO deductible and coinsurance. (No copay)</p> <p><b>Non-PPO:</b> Subject to the Non-PPO deductible, PPO coinsurance and Non-PPO coinsurance limit. (No copay)</p> <p><b>All other active employees and those who retired after 9/15/2009:</b>  <b>PPO:</b> \$50 copay per visit, then subject to the PPO deductible and coinsurance</p> <p><b>Non-PPO:</b> \$50 copay per visit, then subject to the Non-PPO deductible, PPO coinsurance and Non-PPO coinsurance limit</p>	<p>This copay does not apply to the out-of-pocket limit.</p> <p>Per healthcare reform, non-grandfathered plans must apply the PPO coinsurance to Emergency services for all PPO and Non-PPO providers.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room.</p> <p>This copay is waived if you are admitted to the hospital from the emergency room.</p> <p>Emergency room treatment is limited to emergencies, as defined in this plan.</p>	1-15

**On page 1-14, the Wellness Benefit section is deleted and replaced with the following:**

## **WELLNESS BENEFIT**

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

### **All Covered Persons**

1. Preventive medicine visits (wellness exams);
2. Third party exams and treatments, such as those required for employment and the purchase of insurance;
3. Charges for services that are performed pursuant to state statute or regulation for the purpose of determining the appropriateness of voluntary or involuntary commitment or detention.

### **Screening/Services For All Covered Persons at Appropriate Ages**

1. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy);
2. Elevated cholesterol and lipids;
3. Certain sexually transmitted diseases and HIV (includes counseling);
4. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
5. High blood pressure;
6. Diabetes;
7. Depression.

### **For Women**

1. Screening mammography;
2. Counseling for genetic testing for BRCA breast cancer gene;
3. Screening for cervical cancer including pap smears;
4. Screening for gonorrhea, chlamydia, syphilis;
5. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
6. Instructions to promote and help with breast feeding;
7. Screening for osteoporosis;
8. Counseling for those at high risk for breast cancer for chemoprevention.

### **For Men**

1. Screening for prostate cancer. Limited to once per calendar year;
2. Screening for abdominal aortic aneurysm for those ages 65 and older.

### **For Children**

1. Screening newborns for hearing, thyroid disease, phenylketonuria; sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis;
6. Fluoride for prevention of dental cavities;
7. Counseling for obesity;
8. Required exams for school, sports and camps.

You must not be confined in a hospital or qualified treatment facility and such expenses must not be for the diagnosis or treatment of a specific injury or sickness.

**On page 1-28, Exclusion #5 under the “Physical Appearance” exclusions is amended to read as follows:**

5. Any treatment or services for weight control or reduction. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs, except as specifically stated for preventive counseling; or

**On page 1-28, the following “Note” is added to the “Pre-Existing Conditions” exclusion:**

**Note:** The pre-existing conditions exclusions do not apply to any covered person under age 19.

**On page 1-29, Exclusion #4 under the “Reproduction” exclusions is amended to read as follows:**

4. Genetic testing or counseling, unless medically necessary to treat the sickness or injury of a covered person or used in the treatment of a high risk pregnancy, unless specifically stated otherwise as a covered expense;

**On pages 2-4 and 2-5, Item #2 under the definition of “Dependent” is deleted and replaced with the following:**

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

A married or unmarried dependent child may be covered until such child reaches age 26.

After age 26, an unmarried dependent child may be covered until such child reaches age 27, provided such child is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a dependent under the this plan).

Coverage may be extended (beyond age 27) for a dependent child if **all** of the following requirements are met:

- a. The dependent child is a full-time student, regardless of age, and
- b. The dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a dependent under the employee), and
- c. The dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. The dependent child was under age 27 when called to federal active duty.

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

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

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

**On page 2-5, the following is added to the end of the definition of "Dependent":**

**Right To Check Dependent Eligibility**

The plan reserves the right to check the eligibility status of a dependent at any time during the year. You and your dependent have an obligation to notify the plan when the dependent's eligibility status changes during the year. Please notify your employer of any status changes.

**On page 2-5, the definition of "Emergency" is amended to read as follows:**

***Emergency***

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

**On page 2-10, the following "Note" is added to the definition of Pre-Existing Condition:**

**Note:** The pre-existing conditions exclusions do not apply to any covered person under age 19.

**On page 2-10, the Pre-Existing Conditions “Exceptions” section is amended to read as follows”:**

**Pre-Existing Condition Exceptions**

The exclusion will not apply:

- a. to any covered expense due to pregnancy, or
- b. to any condition that has not been diagnosed by a qualified practitioner, but has been indicated by genetic testing.

**On page 3-3, the last paragraph under the “Dependent Effective Date of Coverage” section is deleted in its entirety.**

**On page 3-3, Item #4 under the “Changes in Status” list is amended to read as follows:**

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

**On page 3-5, the “Loss of Other Coverage” list under the Special Enrollment Rights is amended to read as follows:**

**Loss of Other Coverage**

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

1. Ends due to your exhaustion of the maximum COBRA period;
2. Ends due to your loss of eligibility, for any reason; or
3. Ends employer contributions towards the cost of the other coverage

**On page 3-10, the following is added to the Plan, after the “Termination of Coverage” section:**

**Rescission of Coverage**

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

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

1. It has only a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

**On page 4-2, the following is added to the “Coordination of Benefits” section of the plan (before the “Coordination of Benefits between Medical and Dental Plans” section):**

When 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.

**On pages 4-6 and 4-7, the “Claim Review Procedure” section is amended to read as follows.**

### **CLAIM REVIEW PROCEDURE**

The rules stated in this section shall be followed by all persons and entities seeking review of any decision as to eligibility for benefits, the amount of benefits paid or a rescission of coverage determination. These rules shall be the exclusive remedy for any such decision, except as otherwise required by applicable law.

#### **Request for Review**

Any participating employee or beneficiary who has been affected by a decision to deny a claim for benefits, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after the mailing of a written notice of the denial of the claim or of the amount of the benefits to be paid. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

#### **Review**

On timely receipt of a request for review, the Claims Review Committee shall schedule a review within **sixty (60) days** of receipt of the request. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how you may participate in the telephone conference, if you wish. At the telephone conference, you may add any information you wish. However, you may not remain on the telephone conference when the Claims Review Committee deliberates and decides your claims. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the plan will provide that information to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

#### **Decision**

The Claims Review Committee shall issue a written decision within **ten (10) days** after the end of the review, affirming, modifying or setting aside the previous decision or action. The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

To submit a request of claim review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee  
WCA Group Health Trust  
22 East Mifflin Street, Suite 900  
Madison, WI 53703

**On page 4-6, the following is added at the end of the “Claim Review Procedure” section:**

**Federal External Review Program**

The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments, you will be provided with additional information concerning the process. Contact UMR at the telephone number shown on your ID card for more information on the Federal external review program.

WCA Group Health Trust – Marinette County (Medical)  
Amendment #1

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of January 1, 2011.

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**BENEFIT PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:**

BENEFITS PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:

**THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2011.**

**The following definitions are added to the “Definitions” section of the Plan:**

***Post-Service Claim***

Any claim that is not a Pre-Service Claim.

***Pre-Service Claim***

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

***Urgent Care***

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

**In the “General Provisions” section of the Plan, the “Time of Claim Determination” section is deleted and replaced with the following:**

**TIME OF CLAIM DETERMINATION**

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

**Urgent Care**

Within 24 hours or as soon as possible if, Your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the Plan will notify You of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the Plan will give its decision on the claim. If You fail to provide the information requested by the Plan, the Plan will provide You with its decision on the claim within 48 hours of the end of the period that You were given to provide the information.

If You fail to follow the Plan procedure for a Pre-Service Claim, the Plan will notify You within 24 hours of the Plan’s receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

### **Concurrent Care**

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for You to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a Plan Amendment. This will not apply if the benefit is being stopped due to the termination of the Plan.

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, Your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

### **Pre-Service Claims**

Within 15 days of receipt of a non-Urgent Care claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If You fail to follow the Plan procedure for a non-Urgent Care Pre-Service Claim, the Plan will notify You within five days of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

### **Post-Service Claims**

Within 30 days of receipt of the claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

**The "Claim Review Procedure" provision in the General Provisions section of the Plan deleted and replaced with the following:**

## **CLAIM APPEAL PROCEDURE**

A two-level appeal process is available under this Plan, followed by the Federal External Review Program. The first level of appeal is to the Claims Administrator (UMR). If You disagree with the result of the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust).

### **FIRST LEVEL OF APPEAL**

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the Claims Administrator, for a full and fair review of the claim by the Plan;

2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of Your appeal.

A request for a review must be filed with the Claims Administrator within 180 days after receipt of the claim denial. If Your request for review is not received within 180 days, Your right to appeal the claim denial is forfeited.

If Your request for review is received within 180 days, a full and fair review of the claim will be held by the Claims Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

After the review, the Plan's decision will be made to You in writing. It will include specific reasons for the decision as well as specific references to the Plan provisions on which the decision is based. You will be notified of the Plan's decision as follows:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

## **SECOND LEVEL OF APPEAL**

If You disagree with the Plan's decision on the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust) by using the procedures outlined below:

### **Request for Review**

Upon completion of the first level of appeal, any participating Employee or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after receipt of the Plan's decision on the first level of appeal. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

To submit a request for review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee  
WCA Group Health Trust  
22 East Mifflin Street, Suite 900  
Madison, WI 53703

### **Review**

Upon timely receipt of a request for review, the Claims Review Committee will schedule a review of your appeal. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Claims Review Committee will provide that information to You free of charge and sufficiently in advance of the due date of the response to the Your appeal.

### **Decision**

You will be notified of the Claims Review Committee's decision as follows, affirming, modifying or setting aside the previous decision or action:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

### **FEDERAL EXTERNAL REVIEW PROGRAM**

The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments, You will be provided with additional information concerning the process.

Contact UMR, Inc. at the telephone number shown on Your ID card for more information on the Federal external review program.

Claim Appeal Amendment  
January 1, 2011

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2011.

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust  
**SIGNED**  
Title: \_\_\_\_\_

Date: \_\_\_\_\_



**BENEFIT PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:****THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2012.****On page 1-2, the “Certification Procedures” section is deleted and replaced with the following:****PRIOR AUTHORIZATION REQUIREMENTS**

The Utilization Management company (UM) shown on your ID card will handle the authorization requirements of your plan. You should call the UM as soon as possible to receive proper care coordination. However, you must call within the time frames shown below. The UM toll-free number is shown on the back of your ID card.

<b>PRIOR AUTHORIZATION REQUIRED</b>	<b>NON-COMPLIANCE PENALTY</b>	<b>SUMMARY</b>	<b>TEXT PAGE</b>
Inpatient Admissions	No Penalty.	You should call UM for authorization in advance of any Non-Emergency inpatient admission. You should obtain Prior Authorization for all inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery. If admission is on an emergency basis, UM should be notified within the first business day following your admission.	1-11
Chemotherapy	No penalty.	You should notify UM for authorization prior to starting any chemotherapy services.	1-11
Kidney Disease	No penalty.	You should notify UM for authorization prior to starting a course of renal dialysis.	1-11

**PRIOR AUTHORIZATION UM IS NOT A GUARANTEE OF COVERAGE.**

**On page 1-11, the following is added to the Plan:**

## **PRIOR AUTHORIZATION REQUIREMENTS**

### **HOW THE PROGRAM WORKS**

When you call UM, you will be asked the following questions:

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

Prior authorization valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new authorization must be obtained if: you do not receive the treatment within 30 days of the scheduled date; you use a different facility or physician; or you are admitted for a different reason.

### **PRIOR AUTHORIZATION REQUIREMENTS**

You are required to notify UM for authorization prior to receiving certain types of health care. The services that require prior authorization are listed on the Schedule of Benefits. **If you are required to provide prior authorization and fail to do so, benefits may be reduced or denied.**

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

If your treatment is not a covered expense, no benefits will be payable under the plan.

### **NOTICE SECONDARY COVERAGE WAIVER**

If this plan is secondary to another medical plan that also covers you, prior authorization will not be required.

### **CASE MANAGEMENT**

Case management services help you use your benefits wisely during periods of treatment due to a serious sickness or injury. This is done through early identification of the need for case management in UM, followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The case manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

The case management staff at UM consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to you, your doctors and your employer, case management helps to control health care costs and use your benefits wisely.

**On page 1-27, the “Experimental or Unproven Services” exclusion is amended to read as follows:**

**EXPERIMENTAL OR UNPROVEN SERVICES**

1. Any drug or medicine which is not approved for marketing by the United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration. This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection;
2. Any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States;
3. Any medical or surgical procedure which as of the time services are performed is conducted consistent with an experimental or investigative protocol of the United States Department of Health and Human Services or any of its subsidiary Agencies, Bureaus, Institutes or Divisions; or
4. Any **medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect** on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study’s setting. Decisions to cover, or exclude, a treatment will be based on the conclusions of prevailing medical research.

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

When you desire Experimental or Unproven services in response to a Qualified Practitioner’s recommendations, the plan administrator will evaluate such a request for payment of benefits. Such evaluations and benefits are provided at the plan administrator’s sole discretion and will create no obligation with respect to future cases.

**On page 2-9, the definition of “Medically Necessary or Medical Necessity” is amended to read as follows:**

***Medically Necessary***

Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

3. Not mainly for your convenience or that of your qualified practitioner; and
4. 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 sickness, injury, or symptoms.

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

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

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

The Utilization Management company (UM) 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 UM and revised from time to time), are available to you by calling UMR, Inc. at the telephone number shown on your ID card, and to qualified practitioners, physicians and other health care professionals on UnitedHealthcareOnline.com.

**On page 2-12, the definition of “Usual, Customary and Reasonable” (UCR) is amended to read as follows:**

***Usual, Customary and Reasonable (UCR)***

For Non-PPO Providers, the lesser of the fee most often charged by the provider or the maximum allowable fee as determined by the plan. The maximum allowable fee is set by comparing the service to a national database of fees. The database is adjusted to the locality where the service was performed.

1. If more than one surgery is performed during an operative session, the covered expense will be limited. The usual, customary and reasonable (UC&R) fee for the primary surgical procedure will be payable. 50% of the UC&R fee for the secondary procedure will be payable. 50% of the UC&R fee for the third and following procedures will be payable.
2. The UC&R fee for an assistant surgeon or physician's assistant is based on the UC&R fee for the primary surgeon as follows: 16% for an assistant surgeon; and 14% for a physician's assistant.

In the case of a PPO Provider, it will mean the negotiated PPO discount rate for the service or procedure.

**The following definition is added to the “Definitions” section of the Plan:**

***Prior Authorization***

The process of determining benefit coverage prior to service being rendered to a covered person. A determination is made based on medical necessity (medically necessary) criteria for services, tests or procedures that are appropriate and cost-effective for the covered person. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2012.

**TRUST APPROVAL**

By: _____	By: _____
Authorized Representative	Authorized Representative WCA Group Health Trust
Title: _____	Title: _____
Date: _____	Date: _____

SIGNED

**BENEFIT PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2012.

On page 2-4, Item #2 under the definition of “Dependent” is deleted and replaced with the following:

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

The limiting age for each dependent child is the last day of the month in which such child reaches age 26.

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

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

Dependent children who are eligible for this extension, covered under the plan and drop below full-time student status due to injury or sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the plan by the child’s attending qualified practitioner:

1. the date the child’s coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

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

On page 4-14, the “Federal External Review Program” section (under Claim Appeals) is deleted and replaced with the following:

**FEDERAL EXTERNAL REVIEW PROGRAM**

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;
2. The exclusion for experimental or investigational services or unproven services; or
3. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR, Inc. or Your Employer fail to respond to Your appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither You nor UMR, Inc. or Your Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR, INC.  
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, when applicable;
4. The service that was denied; and
5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a Covered Expense by the Plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or Your Employer. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or Your Employer in making a decision on the case;  
and

3. All other information or evidence that You or Your physician has already submitted to UMR, Inc. or Your Employer.

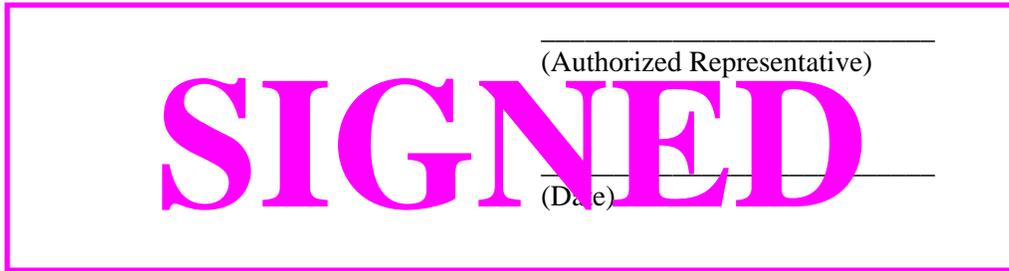
If there is any information or evidence You or Your physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR, Inc. and/or Your Employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

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.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2012.

  
**SIGNED**  
(Authorized Representative)  
(Date)

BENEFITS PLAN AMENDMENT

IT IS UNDERSTOOD AND AGREED THAT:

**In the COBRA section of the Plan, the third paragraph under the section entitled “Additional Election Period Due to The Trade Act of 2002” is amended to read as follows:**

**Additional Election Period due to The Trade Act of 2002**

If You did not elect COBRA during the election period described above, another 60 day period may be presented for You to elect COBRA. If Your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and You are determined to be TAA eligible during the six month period following Your loss of coverage, You will have an additional period in which to elect COBRA. This election period will begin the first of the month in which You become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following Your loss of coverage due to a TAA event.

If You elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which You became TAA eligible. COBRA will not be provided for the period of time between Your loss of coverage and the first of the month in which You became TAA eligible. However, that time will not be counted as a lapse in coverage for purposes of determining if the Plan’s pre-existing condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date You lost coverage under the Plan, not the date COBRA is effective. If You do not elect COBRA within this period, COBRA will not be available again.

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 72.5% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If You have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of October 1, 2011.

By: \_\_\_\_\_  
Authorized Representative - WCA Group Health Trust

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**SIGNED**



**BENEFIT PLAN AMENDMENT  
 IT IS UNDERSTOOD AND AGREED THAT:**

**THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JULY 1, 2012.**

On page 1-9, the Vision Benefit section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Vision Benefit (Eye Exams, Glasses and Contact Lenses)  <b>The following locations do <u>not</u> have these vision benefits: 0010, 0556, 0887</b>	100%, deductible and coinsurance waived (for PPO and Non-PPO providers)	<p><b><u>Note:</u> The following locations do <u>not</u> have these vision benefits: 0010, 0556, and 0887.</b></p> <p>Benefits include routine and medically necessary eye exams, refractions, eyeglasses, contact lenses and charges for radial keratotomy and Lasik surgery to correct refractive disorders</p> <p>Limited to \$100 paid per calendar year. (If an eye exam is medically necessary and the \$100 benefit has already been paid for the current calendar year, covered expenses for medically necessary eye exams will be subject to the deductible and coinsurance.)</p>	1-23

On page 1-23, Item #21 under the Other Covered Expenses is amended to read as follows:

- 21. Vision Benefit. Benefits include routine and medically necessary eye exams, refractions, eyeglasses and contact lenses and charges for radial keratotomy or Lasik surgery to correct refractive disorders. Benefits are payable as shown on the Schedule of Benefits. Contact lens solutions and contact lens supplies are not covered expenses under this Plan. (**Note:** The following locations do not have these vision benefits: 0010, 0556 or 0887.)

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of July 1, 2012.

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_





**BENEFIT PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2013.

On page 1-7, the Pregnancy Benefit section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pregnancy Benefit	Subject to the deductible and coinsurance	Covered for employee, dependent spouse and dependents.  Charges for routine pre-natal care and routine screening for gestational diabetes are payable as shown under the Wellness Benefit. (This also applies to Dependent daughter maternity, even if the Plan does not cover Dependent daughter maternity. This does not apply to high risk pregnancy or complications of pregnancy.)	1-16

On page 1-12, Item #5 (sterilizations, etc.) is removed from the Qualified Practitioner Benefit. (Note: Such services may be covered under the Wellness Benefit. Refer to the “For Women” and “For Men” lists under the Wellness Benefit for more information.)

On page 1-14, the Wellness Benefit is amended to read as follows:

**WELLNESS BENEFIT**

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

**All Covered Persons**

1. Preventive medicine visits (wellness exams);
2. Third party exams and treatments, such as those required for employment and the purchase of insurance;
3. Charges for services that are performed pursuant to state statute or regulation for the purpose of determining the appropriateness of voluntary or involuntary commitment or detention.

## Screening/Services For All Covered Persons at Appropriate Ages

1. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy);
2. Elevated cholesterol and lipids;
3. Certain sexually transmitted diseases and HIV (includes counseling);
4. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
5. High blood pressure;
6. Diabetes;
7. Depression.

## For Women

1. Screening mammography;
2. Counseling for genetic testing for BRCA breast cancer gene;
3. Screening for cervical cancer including pap smears;
4. Screening for gonorrhea, chlamydia, syphilis;
5. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
6. Instructions to promote and help with breast feeding;
7. Screening for osteoporosis;
8. Counseling for those at high risk for breast cancer for chemoprevention;
9. Gynecological exams;
10. Routine pre-natal care;
11. Routine gestational diabetes screening;
12. Human papillomavirus (HPV) DNA testing for any covered female person;
13. Counseling for sexually transmitted infections (provided annually);
14. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
15. Breastfeeding support, supplies and counseling in conjunction with each birth. Benefits include comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and charges for the rental or purchase of breastfeeding equipment. (**NOTE: Retail and over-the-counter equipment and supplies are not covered.**)
16. Screening and counseling for interpersonal and domestic violence (provided annually);
17. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), such as insertable vaginal devices (e.g. Nuva ring), injections and administration, devices (e.g. IUD, implants) including insertion and removal, sterilizations (for any covered female person), patient education and related office services. (**Note:** Birth control pills and patches may be covered under the Drug Card. Birth control that is not covered under the Drug Card will be covered under this benefit.)

Please visit the following links for additional information:

<http://www.healthcare.gov/law/resources/regulations/prevention>

or

<http://www.hrsa.gov/womensguidelines/>

## For Men

1. Screening for prostate cancer. Limited to once per calendar year;
2. Screening for abdominal aortic aneurysm for those ages 65 and older;
3. Human papillomavirus (HPV) DNA testing;
4. Counseling for sexually transmitted infections (provided annually);
5. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
6. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), including sterilizations (for any covered male person), patient education and related office services;
7. Screening and counseling for interpersonal and domestic violence (provided annually).

Marinette County (Dental) - Effective 1/1/10

**For Children**

1. Screening newborns for hearing, thyroid disease, phenylketonuria; sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis;
6. Preventive/routine oral fluoride supplements prescribed for dependent children ages six months to five years old whose primary water source is deficient in fluoride;
7. Counseling for obesity;
8. Required exams for school, sports and camps.

You must not be confined in a hospital or qualified treatment facility and such expenses must not be for the diagnosis or treatment of a specific injury or sickness.

On page 1-24, Item #28 (birth control) is removed from the list of Other Covered Expenses. (Note: Contraceptive services may be covered under the Wellness Benefit. Refer to the Wellness Benefit for more information.)

WCA Group Health Trust  
Health Care Reform/Expanded Women's Preventive Health  
Effective January 1, 2013

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2013.

By: \_\_\_\_\_  
Authorized Representative

**SIGNED**

Title: \_\_\_\_\_

Date: \_\_\_\_\_

AMENDMENT #8

WCA Group Health Trust – Marinette County (Medical)  
Group Number: WCA0038

**BENEFITS PLAN AMENDMENT  
IT IS UNDERSTOOD AND AGREED THAT:**

**THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE OCTOBER 1, 2012.**

On page 1-5, the Qualified Practitioner Benefit is amended to read as follows:

<b>COVERED EXPENSES</b>	<b>PAYABLE AT</b>	<b>BENEFIT SUMMARY</b>	<b>TEXT PAGE</b>
Qualified Practitioner Benefits	Subject to the deductible and coinsurance	Inpatient and outpatient hospital visits, home and office visits, surgery and anesthesia.	
Convenient Care Clinics	PPO: 100%, deductible and coinsurance waived		
	Non-PPO: Subject to the deductible and coinsurance		

On page 1-11, the 4<sup>th</sup> Quarter Deductible Carryover provision is deleted from the Plan in its entirety.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of October 1, 2012.

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**BENEFITS PLAN AMENDMENT  
 IT IS UNDERSTOOD AND AGREED THAT:**

**THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2013.**

On page 1-2, the Prior Authorization Requirements section is amended to read as follows:

**PRIOR AUTHORIZATION REQUIREMENTS**

The Utilization Management company (UM) shown on your ID card will handle the authorization requirements of your plan. You should call the UM as soon as possible to receive proper care coordination. However, you must call within the time frames shown below. The UM toll-free number is shown on the back of your ID card.

<b>PRIOR AUTHORIZATION REQUIRED</b>	<b>NON-COMPLIANCE PENALTY</b>	<b>SUMMARY</b>	<b>TEXT PAGE</b>
Inpatient Admissions	No Penalty.	<p><b>PPO: <u>Your PPO provider</u></b> is required to notify UM for authorization.</p> <p><b>Non-PPO: <u>You</u></b> should call UM for authorization in advance of any Non-Emergency inpatient admission. You should obtain Prior Authorization for all inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery. If admission is on an emergency basis, UM should be notified within the first business day following your admission.</p>	
Chemotherapy	No penalty.	<p><b>PPO: <u>Your PPO provider</u></b> is required to notify UM for authorization.</p> <p><b>Non-PPO: <u>You</u></b> should notify UM for authorization prior to starting any chemotherapy services.</p>	

PRIOR AUTHORIZATION REQUIRED	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Kidney Disease	No penalty.	<p><b>PPO: <u>Your PPO provider</u></b> is required to notify UM for authorization.</p> <p><b>Non-PPO: <u>You</u></b> should notify UM for authorization prior to starting a course of renal dialysis.</p>	

PRIOR AUTHORIZATION UM IS NOT A GUARANTEE OF COVERAGE.

On pages 1-3 and 1-4, the Medical Benefits portion of the Schedule of Benefits is amended to read as follows:

#### MEDICAL BENEFITS

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per calendar year PPO Individual Family  Non-PPO Individual Family	\$0 \$0  \$0 \$0	\$300 \$600  \$551 \$1,102	The amount you must pay each year before the plan will begin paying any benefits.  PPO and Non-PPO family maximums are on an aggregate dollar basis.	
Individual coinsurance per calendar year PPO  Non-PPO	90%  70%	10%  30%	After the deductible, the coinsurance amounts shown apply. After which the plan pays 100% of covered expenses subject to any maximums.	

Marinette County (Dental) - Effective 1/1/10

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Out-of-Pocket limit per calendar year  PPO Individual Family  Non-PPO Individual Family		\$350 \$700  \$1,500 \$3,000	Represents the total paid by you for the <b>coinsurance</b> . After which the plan pays 100% of covered expenses subject to any maximums. (The deductible is <u>not</u> included in the out-of-pocket limit. It is in addition to it.)  PPO and Non-PPO family maximums are on an aggregate dollar basis.	

All covered expenses under the plan are payable at the plan's usual, customary and reasonable limits. The deductible and coinsurance limits shown above apply to all covered expenses unless stated otherwise below.

**PPO Benefit Provision**

PPO Benefits will be payable for Non-PPO provider services **only** if:

1. You require emergency medical care.
2. The required medical services are not available from a PPO provider.
3. PPO benefits will be payable for Non-PPO provider services only if you receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred from a Non-PPO provider that is a: pathologist; anesthesiologist; cardiologist; radiologist or emergency Room physician and independent labs.

On pages 1-6 and 1-15, the Supplemental Accident Benefit is deleted from the Plan in its entirety.

On page 1-11, the Prior Authorization Requirements section is amended to read as follows:

**PRIOR AUTHORIZATION REQUIREMENTS**

You or Your Qualified Practitioner are required to obtain Prior Authorization from UM prior to receiving certain types of health care. The services that require Prior Authorization are listed on the Schedule of Benefits.

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

If your treatment is not a covered expense, no benefits will be payable under the plan.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2013.

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_