MARQUETTE UNIVERSITY
MILWAUKEE WI

Health Benefits Plan Document And
Summary Plan Description
7670-00-040178

Revised 01-01-2013

BENEFITS ADMINISTERED BY

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MARQUETTE UNIVERSITY

HEALTH BENEFITS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective: 01-01-2013

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. As a valued employee of MARQUETTE UNIVERSITY, we are pleased to provide You with benefits that can help meet Your health care needs.

MARQUETTE UNIVERSITY is named the Plan Administrator for this group health plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, to process claims and handle other duties for this self-funded Plan. UMR, does not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Employer assumes the sole responsibility for funding the employee benefits out of general assets, however employees help cover some of the costs of covered benefits through premium contributions, Deductibles, Co-pays and Coinsurance amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though it normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group health plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this booklet. Please read this document carefully and contact Your Human Resources department if You have questions.

If You haven't already received this, You will be getting an Identification Card that You should present to the provider when You receive services. This card also has phone numbers on the back of the card so You know who to call if You have questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD"). It is being furnished to You in accordance with ERISA.

This Plan becomes effective on January 1, 2004, revised on January 1, 2010, revised on January 1, 2011, revised on January 1, 2012 and revised on January 1, 2013.

PLAN INFORMATION

Effective: 01-01-2013

Plan Name	MARQUETTE UNIVERSITY SELF-FUNDED HEALTH AND DENTAL PLAN
Name and Address of Employer	MARQUETTE UNIVERSITY 915 W WISCONSIN AVE STRAZ TOWER #185 - HR MILWAUKEE WI 53233
Name, Address and Phone Number Of Plan Administrator	MARQUETTE UNIVERSITY 915 W WISCONSIN AVE STRAZ TOWER #185 - HR MILWAUKEE WI 53233 414-288-7305
Named Fiduciary	PLAN ADMINISTRATOR
Employer identification number assigned by the IRS	39-0806251
Plan number assigned by the Plan	501
Type of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits This Plan is maintained pursuant to a collective bargaining arrangement between the Plan Sponsor and the Service Employees International Union (SEIU Local 1), which provides that members of one or more collective bargaining groups may participate in this Plan. The collective bargaining agreement(s) are available upon written request.
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the employer's health benefits plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments and enrollment.
Agent for Service of Legal Process	Marquette University – Office of the General Counsel

Funding of the Plan	Employer and Employee Contributions Employees that participate in the annual Wellness Health Risk Assessment will be eligible for a medical plan contribution discount. Part-time regular Employees and Retirees contribute 100% of the premium rates. Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer. No Tax Representations. Covered Persons shall be solely responsible for the tax consequences of participation or non-participation in any benefit program and no provision in this Plan or any Insurance Contract shall constitute or be construed as a representation or guarantee of what those tax consequences will be.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31
ERISA and other federal compliance	It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator and other parties assuming a Fiduciary role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

Participant Acceptance

Enrollment in the Plan constitutes acceptance by the Participant and on behalf of his/her Dependents of all the terms and conditions of the Plan and the benefit program.

BENEFIT CLASS DESCRIPTION

Effective: 01-01-2012

The Covered Person's benefit class is determined by the designations shown below:

Class	Class Description	Benefit Plan	Network**
A01	**Effective: 01-01-2012 Class Amended** ALL ACTIVE EMPLOYEES WITH EPO	001	0L
A03	**Effective: 01-01-2012 Class Amended** ALL ACTIVE EMPLOYEES WITH PPO	003	0L-ZM
C01	**Effective: 01-01-2012 Class Amended** ALL COBRA PARTICIPANTS AND LTD EMPLOYEES WITH EPO	001	0L
C03	**Effective: 01-01-2012 Class Amended** ALL COBRA PARTICIPANTS AND LTD EMPLOYEES WITH PPO	003	0L-ZM
R01	**Effective: 01-01-2012 Class Amended** ALL RETIRED EMPLOYEES WITH EPO	001	0L
R03	**Effective: 01-01-2012 Class Amended** ALL RETIRED EMPLOYEES WITH PPO	003	0L-ZM
R05	ALL RETIRED EMPLOYEES WITH HIGH DEDUCTIBLE PLAN	005	0L-ZM

**Note: See Provider Network section of this SPD for network description.

LOCATION DESCRIPTION

Effective Date	Termination Date	Location	Description	Billing Division	Reporting Sub.
01-01-2004		000	MARQUETTE UNIVERSITY 915 W WISCONSIN AVE STRAZ TOWER #185 - HR MILWAUKEE WI 53233	001	0000
01-01-2004		001	MU - STAFF F/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0001
01-01-2004		002	MU - FACULTY F/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0002
01-01-2004		003	MU - ADMIN F/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0003
01-01-2004		004	MU - STAFF F/T TEMP PO BOX 1881 MILWAUKEE WI 53201-1881	001	0004
01-01-2004		005	MU - FACULTY F/T TEMP PO BOX 1881 MILWAUKEE WI 53201-1881	001	0005
01-01-2004		006	MU - ADMIN F/T TEMP PO BOX 1881 MILWAUKEE WI 53201-1881	001	0006
01-01-2004		007	MU - STAFF P/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0007
01-01-2004		008	MU - FACULTY P/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0008
01-01-2004		009	MU - ADMIN P/T REG PO BOX 1881 MILWAUKEE WI 53201-1881	001	0009
01-01-2004		010	MU - RETIREES PRE 65 PO BOX 1881 MILWAUKEE WI 53201-1881	001	0010
01-01-2004		011	MU - RETIREES POST 65 PO BOX 1881 MILWAUKEE WI 53201-1881	001	0011

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001 EPO

Effective: 01-01-2013

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, and are subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

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

Note: If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that You receive from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum	Unlimited	
Annual Deductible Per Calendar Year:		
• Per Person	$0	$500
• Per Family	$0	$1,000
Coinsurance Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Coinsurance Maximum:		
• Per Person	$0	$750
• Per Family	$0	$1,500
Annual Out-Of-Pocket Maximum (Deductible Plus Coinsurance):		
• Per Person	$0	$1,250
• Per Family	$0	$2,500
Acupuncture Treatment:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Ambulance Transportation:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Autism ABA Therapy To Age 19		
• Paid By Plan After Deductible	100%	80%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Chiropractic Services:		
Office Visit And X-ray:		
• Paid By Plan After Deductible	100%	80%
Manipulations:		
• Co-pay Per Visit	$25	Not Applicable
• Maximum Visits Per Calendar Year	15 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	100%	80%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Durable Medical Equipment: (Subject to Medicare Guidelines)		
• Paid By Plan After Deductible	100%	80%
Emergency Services / Treatment:		
Emergency Room / Emergency Physician Charges:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$150	$150
• Paid By Plan After In-Network Deductible	100%	100%
Hospital-Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100% (Deductible Waived)	80% (Deductible Waived)
Office-Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan After Deductible	100%	80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Paid By Plan After Deductible	100%	80%
Foot Orthotics:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After Deductible	100%	80%
Hearing Deficit Services:		
Hearing Aids:		
• Maximum Benefit Every Three Years	$500	
• Paid By Plan After Deductible	50%	50%
Cochlear Implants:		
• Paid By Plan After Deductible	100%	80%
Home Health Care Benefits:		
• Paid By Plan After Deductible	100%	80%
Hospice Care Benefits:		
• Paid By Plan After Deductible	100%	80%
Hospital Services:		
Inpatient Services Only:		
• Co-pay Per Admission	$375	Not Applicable
• Paid By Plan After Deductible	100%	80%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	100%	80%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
Infertility Services:		
• Maximum Benefit Per Lifetime	$2,500	
• Paid By Plan	50% (Deductible Waived)	50% (Deductible Waived)
Maternity:		
Prenatal:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Delivery And Postnatal:		
• Paid By Plan After Deductible	100%	80%
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Admission	$375	Not Applicable
• Paid By Plan After Deductible	100%	80%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	100%	80%
Outpatient Or Partial Hospitalization:		
• Paid By Plan After Deductible	100%	80%
Office Visit:		
• Primary Care Physician Co-pay Per Visit	$25	Not Applicable
• Specialist Providers Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Substance Abuse And Chemical Dependency Residential Treatment:		
• Co-pay Per Admission	$375	Not Applicable
• Paid By Plan After Deductible	100%	80%
Morbid Obesity:		
Gastric Or Intestinal Bypasses:		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100%	80%
Oral Surgery:		
• Paid By Plan	100% (Deductible Waived)	80% (Deductible Waived)
Orthognathic, Prognathic And Maxillofacial Surgery:		
• Paid By Plan After Deductible	100%	80%
Physician Office Visit:		
Primary Care Physician Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Specialist Providers Office Visit:		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
All Other Services On The Same Day:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Immunizations (See Covered Medical Benefits provision for list of covered immunizations):		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Routine Bone Density Test: Females From Age 65		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Mammograms And Breast Exams: From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: From Age 50		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
***These Services May Also Apply To Men.**		
Routine Abdominal / Aortic Ultrasound: Males Between Ages 65-75		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Hearing Exams For Children: To Age 6		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Sterilizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Temporomandibular Joint Disorder Benefits:		
Surgical Treatment:		
• Paid By Plan After Deductible	100%	80%
Non-Surgical Treatment:		
• Maximum Benefit Per Calendar Year	$2,500	
• Paid By Plan After Deductible	100%	80%
Therapy Services:		
***Outpatient Occupational, Physical, Speech And Aquatic Therapy:** Age 16 And Under (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized)		
• Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
***Outpatient Occupational, Physical And Aquatic Therapy:** Age 17 And Over (Treatment Must Be Preauthorized After 24 Sessions) • Paid By Plan After Deductible	100%	80%
***Speech Therapy** Age 17 and Over (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized) • Paid By Plan After Deductible	100%	80%
****Note: Therapy Rendered At Marquette's Physical Therapy Clinic Is Covered At 100% With No Deductible, Coinsurance, Or Co-pay (Not Including X-rays Or Other Procedures Outside The Scope Of Therapy).***		
Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$500 100%	100%
All Other Covered Expenses: • Paid By Plan After Deductible	100%	80%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003 PPO

Effective: 01-01-2013

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, and are subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

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

Note: If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that You receive from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum	Unlimited	
Annual Deductible Per Calendar Year:		
• Per Person	$500	$1,000
• Per Family	$1,000	$2,000
Coinsurance Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Coinsurance Maximum:		
• Per Person	$750	$1,500
• Per Family	$1,500	$3,000
Annual Out-Of-Pocket Maximum (Deductible Plus Coinsurance):		
• Per Person	$1,250	$2,500
• Per Family	$2,500	$5,000
Acupuncture Treatment:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Ambulance Transportation:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Autism ABA Therapy To Age 19		
• Paid By Plan After Deductible	80%	60%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
Office Visit and X-ray:		
• Paid By Plan After Deductible	100%	60%
Manipulations:		
• Co-pay Per Visit	$25	Not Applicable
• Maximum Visits Per Calendar Year	15 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	80%	60%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Durable Medical Equipment: (Subject to Medicare Guidelines)		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Emergency Room / Emergency Physician Charges:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$150	$150
• Paid By Plan After In-Network Deductible	80%	80%
Hospital Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan	80% (Deductible Waived)	60% (Deductible Waived)
Office Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan After Deductible	80%	60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Sub-acute Facility:		
• Paid By Plan After Deductible	80%	60%
Foot Orthotics:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After Deductible	80%	60%
Hearing Deficit Services:		
Hearing Aids:		
• Maximum Benefit Every Three Years	$500	
• Paid By Plan After Deductible	50%	50%
Cochlear Implants:		
• Paid By Plan After Deductible	80%	60%
Home Health Care Benefits:		
• Paid By Plan After Deductible	80%	60%
Hospice Care Benefits:		
• Paid By Plan After Deductible	80%	60%
Hospital Services:		
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Infertility Services:		
• Maximum Benefit Per Lifetime	$2,500	
• Paid By Plan	50% (Deductible Waived)	50% (Deductible Waived)
Maternity:		
Prenatal:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Delivery And Postnatal:		
• Paid By Plan After Deductible	80%	60%
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services / Inpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization:		
• Paid By Plan After Deductible	80%	60%
Office Visit:		
• Primary Care Physician Co-pay Per Visit	$25	Not Applicable
• Specialist Providers Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Substance Abuse And Chemical Dependency Residential Treatment:		
• Paid By Plan After Deductible	80%	60%
Morbid Obesity:		
Gastric Or Intestinal Bypasses		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	80%	60%
Oral Surgery:		
• Paid By Plan	80% (Deductible Waived)	60% (Deductible Waived)
Orthognathic, Prognathic And Maxillofacial Surgery:		
• Paid By Plan After Deductible	80%	60%
Physician Office Visit:		
Primary Care Physician Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Specialist Providers Office Visit:		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
All Other Services On The Same Day:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Immunizations (See Covered Medical Benefits provision for list of covered immunizations):		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Routine Bone Density Test:		
Females From Age 65		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams:		
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
From Age 50		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
***These Services May Also Apply To Men.**		
Routine Abdominal/Aortic Ultrasound: Males Between Ages 65-75		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams For Children: To Age 6		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Sterilizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Temporomandibular Joint Disorder Benefits:		
Surgical Treatment:		
• Paid By Plan After Deductible	80%	60%
Non-Surgical Treatment		
• Maximum Benefit Per Calendar Year	$2,500	
• Paid By Plan After Deductible	80%	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Therapy Services: ***Outpatient Occupational, Physical, Speech And Aquatic Therapy:** Age 16 And Under (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized) • Paid By Plan After Deductible	80%	60%
***Outpatient Occupational, Physical And Aquatic Therapy:** Age 17 And Over (Treatment Must Be Preauthorized After 24 Sessions)) • Paid By Plan After Deductible	80%	60%
***Speech Therapy** Age 17 and Over (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized) • Paid By Plan After Deductible	80%	60%
****Note: Therapy Rendered At Marquette's Physical Therapy Clinic Is Covered At 100% With No Deductible, Coinsurance, Or Co-pay (Not Including X-rays Or Other Procedures Outside The Scope Of Therapy).***		
Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata: • Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After In-Network Deductible	80%	80%
All Other Covered Expenses: • Paid by Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 005 High Deductible (Retirees Only)

Effective: 01-01-2013

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, and are subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

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

Note: If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that You receive from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum	Unlimited	
Annual Deductible Per Calendar Year:		
• Per Person	$4,500	$5,000
• Per Family	$9,000	$10,000
Coinsurance Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Coinsurance Maximum:		
• Per Person	$500	$2,000
• Per Family	$1,000	$4,000
Annual Out-Of-Pocket Maximum (Deductible Plus Coinsurance):		
• Per Person	$5,000	$7,000
• Per Family	$10,000	$14,000
Acupuncture Treatment:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Ambulance Transportation:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Autism ABA Therapy To Age 19		
• Paid By Plan After Deductible	80%	60%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
Office Visit and X-ray:		
• Paid By Plan After Deductible	100%	60%
Manipulations:		
• Co-pay Per Visit	$25	Not Applicable
• Maximum Visits Per Calendar Year	15 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	80%	60%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Durable Medical Equipment: (Subject to Medicare Guidelines)		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Emergency Room / Emergency Physician Charges:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$150	$150
• Paid By Plan After In-Network Deductible	80%	80%
Hospital Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan	80% (Deductible Waived)	60% (Deductible Waived)
Office Based Urgent Care:		
• Co-pay Per Visit	$50	$50
• Paid By Plan After Deductible	80%	60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Sub-acute Facility:		
• Paid By Plan After Deductible	80%	60%
Foot Orthotics:		
• Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After Deductible	80%	60%
Hearing Deficit Services:		
Hearing Aids:		
• Maximum Benefit Every Three Years	$500	
• Paid By Plan After Deductible	50%	50%
Cochlear Implants:		
• Paid By Plan After Deductible	80%	60%
Home Health Care Benefits:		
• Paid By Plan After Deductible	80%	60%
Hospice Care Benefits:		
• Paid By Plan After Deductible	80%	60%
Hospital Services:		
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Infertility Services:		
• Maximum Benefit Per Lifetime	$2,500	
• Paid By Plan	50% (Deductible Waived)	50% (Deductible Waived)
Maternity:		
Prenatal:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Delivery And Postnatal:		
• Paid By Plan After Deductible	80%	60%
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services / Inpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization:		
• Paid By Plan After Deductible	80%	60%
Office Visit:		
• Primary Care Physician Co-pay Per Visit	$25	Not Applicable
• Specialist Providers Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Substance Abuse And Chemical Dependency Residential Treatment:		
• Paid By Plan After Deductible	80%	60%
Morbid Obesity:		
Gastric Or Intestinal Bypass:		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	80%	60%
Oral Surgery:		
• Paid By Plan	80% (Deductible Waived)	60% (Deductible Waived)
Orthognathic, Prognathic And Maxillofacial Surgery:		
• Paid By Plan After Deductible	80%	60%
Physician Office Visit:		
Primary Care Physician Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Specialist Providers Office Visit:		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
All Other Services On The Same Day:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Immunizations (See Covered Medical Benefits provision for list of covered immunizations):		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Routine Bone Density Test:		
Females From Age 65		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams:		
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
From Age 50		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Effective: 01-01-2013	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• **Paid By Plan After Deductible**	100% (Deductible Waived)	60%
***These Services May Also Apply To Men.**		
Routine Abdominal/Aortic Ultrasound: Males Between Ages 65-75		
• Maximum Benefit Per Lifetime	1	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams For Children: To Age 6		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Sterilizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Temporomandibular Joint Disorder Benefits:		
Surgical Treatment:		
• Paid By Plan After Deductible	80%	60%
Non-Surgical Treatment		
• Maximum Benefit Per Calendar Year	$2,500	
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Therapy Services: ***Outpatient Occupational, Physical, Speech And Aquatic Therapy:** Age 16 And Under (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized) • Paid By Plan After Deductible	80%	60%
***Outpatient Occupational, Physical And Aquatic Therapy:** Age 17 And Over (Treatment Must Be Preauthorized After 24 Sessions)) • Paid By Plan After Deductible	80%	60%
***Speech Therapy** Age 17 and Over (Allow Initial Evaluation – Additional Treatment Must Be Preauthorized) • Paid By Plan After Deductible	80%	60%
****Note: Therapy Rendered At Marquette's Physical Therapy Clinic Is Covered At 100% With No Deductible, Coinsurance, Or Co-pay (Not Including X-rays Or Other Procedures Outside The Scope Of Therapy).***		
Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata: • Maximum Benefit Per Calendar Year	$500	
• Paid By Plan After In-Network Deductible	80%	80%
All Other Covered Expenses: • Paid by Plan After Deductible	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 001 (EPO) Effective: 01-01-2012		
Transplant Services At A Designated Transplant Facility: • Paid By Plan	100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services At A Non-designated Transplant Facility: • Paid By Plan After Deductible	100%	80%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 003 and 005 (PPO & High Deductible) Effective: 01-01-2013		
Transplant Services At A Designated Transplant Facility • Paid By Plan	100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services At A Non-designated Transplant Facility: • Paid By Plan After Deductible	80%	60%

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Applies to Benefit Plan(s) 001 EPO

Effective: 01-01-2012

CO-PAYS

A Co-pay is the amount shown on the Schedule of Benefits that the Covered Person must pay to the provider each time certain services are received.

The office Co-pay applies to Physician office visits, in addition to the Co-pays listed on the Schedule of Benefits.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Applies to Benefit Plan(s) 003 PPO and 005 High Deductible

Effective: 01-01-2012

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of yearly out-of-pocket maximums. The Co-pay, out-of-pocket maximum, Deductible(s) and Plan Coinsurance are shown on the Schedule of Benefits.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise.

Only Covered Expenses will count toward meeting the Deductible. Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether incurred at a Participating or Non-Participating Provider) will be used to satisfy the total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and incurred during that calendar year.

PLAN COINSURANCE

Plan Coinsurance means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses, until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Coinsurance rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, negotiated rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, Deductibles and Plan Coinsurance expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

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

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this SPD.
- Co-pays and Coinsurance amounts for Prescription products.
- Infertility services.
- Out-of Network Routine Benefits.
- Any amounts over the Usual and Customary amount, negotiated rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether incurred at a Participating or Non-Participating Provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

ELIGIBILITY AND ENROLLMENT

Effective: 01-01-2013

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Employees that are eligible and enroll for medical plan coverage, including employees hired after the Annual Enrollment period, will also have the opportunity to participate in a health risk assessment. Employees that complete all components of the health risk assessment will be eligible for a premium contribution discount. All medical plan participants will be given the opportunity to complete the health risk assessment annually.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time:

- Nonbargaining person, regularly scheduled to work for the Plan holder on a full-time basis for at least 37 ½ hours a week or have a similar academic appointment; or
- Bargaining person, regularly scheduled to work for the Plan holder for at least 30 hours a week; or
- Regularly scheduled to work for the Plan holder on a part-time basis for at least 80 hours a month/minimum of 1000 hours per year; or
- Full-time temporary, minimum of a 1 calendar/academic year contract.

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this SPD.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

Effective: 01-01-2012

An **eligible Dependent** includes:

- Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act or your domestic partner who is a person of the same sex with whom you have established a Domestic Partnership provided your spouse or domestic partner is not covered as an employee under this Plan. All references to the spouse of an employee shall include a domestic partner. An eligible Dependent does not include an individual from whom you have obtained a legal separation or divorce unless court ordered. Documentation on a Covered Person's marital or domestic partner status may be required by the Plan Administrator.

- A Dependent child that resides in the United States until the child reaches his or her 26th birthday. The term "**child**" includes the following Dependents:

  - A natural biological child;
  - A step child;
  - A legally adopted child or a child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 26 as of the date of such placement;
  - A child under Your (or Your spouse's or domestic partner's) Legal Guardianship as ordered by a court;
  - A child who is considered an alternate recipient under a Qualified Medical Child Support Order;

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible employee shall not also be considered an eligible Dependent under this Plan. An eligible Child will not be covered if the Child is covered as a Dependent of another Employee at this company.

Employees have the right to choose which eligible Dependents are covered under the Plan.

LEAVE OF ABSENCE AND FAMILY AND MEDICAL LEAVE ACT

An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis.

If an Employee is on leave as provided by the Family and Medical Leave Act (FMLA), your share of the cost must be paid using one of three methods: pay in advance, pay-as-you-go, or catch-up contributions upon return to work. If you elect not to return to work for at least 30 days at the end of the leave period, you will be required to reimburse the Employer for the cost of the health benefits paid by the Employer for maintaining coverage during the unpaid leave, unless you cannot return to work because of a serious health condition or circumstances beyond your control. If you fail to return to work on the originally scheduled return date, you will be deemed to have voluntarily terminated employment. Health benefits will terminate on the last day of the leave.

Coverage will be continued for up to the greater of:

- The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes actively at work:

- No new Waiting Period will apply; and
- The Pre-Existing Conditions Exclusion shall apply only to the extent it was not satisfied prior to the leave.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR COVERED CHILDREN

Coverage under this Plan may be extended for a covered Child if the following conditions are met:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the covered Child fits the following category:

If You have a Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue as long as the Child is deemed to be Totally Disabled under the terms of the Plan subject to the following minimum requirements:

- The Child must be dependent on the Employee or Spouse for more than half of his or her support; and
- The Child must not be able to hold a self-sustaining job due to the disability; and
- Proof must be submitted as required; and
- The Employee must still be covered under this Plan.

A Child who has not attained the age of 26 may re-enroll in the Plan when eligibility is met, subject to the Plan terms if the Child becomes Totally Disabled.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the official date of hire.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

Effective: 01-01-2012

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The date specified in a Qualified Medical Child Support Order.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL ENROLLMENT PERIOD

During the annual enrollment period, eligible employees and retirees will be able to enroll themselves and their eligible Dependents for coverage under this Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual group annual enrollment period, the following shall apply:

- The employer will give eligible employees written notice prior to the start of an annual enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The effective date of any eligible individual requesting coverage during the annual enrollment period will be January 1 immediately following completion of the annual enrollment period.

DECLINING ENROLLMENT PROVISION

If You decline coverage for yourself or Your Dependents because of other group health coverage or health insurance, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You apply within 30 days after Your other coverage ends.

In addition, if You have a new Dependent as a result of marriage, birth, adoption or placement for adoption, You may be able to enroll yourself and certain Dependents, provided that You apply for enrollment within 30 days of marriage, birth, adoption or Placement for Adoption. Refer to the Special Enrollment Provision in this document.

TERMINATION

Effective: 01-01-2012

Please see the COBRA section of this SPD for questions regarding coverage continuation.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual enrollment periods. If you voluntarily terminate your coverage from the 1st – 15th of the month, your coverage will end at the end of the month. If you voluntarily terminate on the 16th of the month or after, your coverage will end the last day of the following month.
- The last day of the month in which You are no longer a member of a covered class, or notice/severance payment expires, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section.
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The last day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the employee resides; or
- The last day of the month in which Your Dependent no longer qualifies as a domestic partner; or
- The last day of the month in which Your Dependent child attains the limiting age listed under the Eligibility section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan.

RESCISSION OF COVERAGE

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

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

- It has only a prospective effect; or
- It is attributable to non-payment of premiums or contributions; or
- Coverage never took effect due to failure to provide any requested documentation regarding Dependent status.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to active work, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

Effective: 01-01-2012

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent. If a Retiree terminates from the plan, the Retiree will not be eligible to reenroll for any reason.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage. Your loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time You declined coverage. The Plan will not recognize Your special enrollment right due to a loss of coverage if other coverage was not in effect at the time You declined enrollment. You declined enrollment if You do not enroll in the Plan during the Plan's annual enrollment period, a special enrollment period or upon COBRA being offered.

You and/or Your Dependents may enroll for health coverage under this Plan (or switch to another Plan option) due to loss of health coverage if the following conditions are met:

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

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

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

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

CHANGE IN FAMILY STATUS

Current employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status. Retired employees who are Covered Persons have a special opportunity to enroll newly acquired Dependents for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period 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. The Employee 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.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

PRE-EXISTING CONDITION PROVISION

Effective: 01-01-2012

Note: Pre-Existing Condition exclusions will not apply to any Covered Person under the age of 19.

A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the three consecutive month period ending on the Covered Person's Enrollment Date. Medical advice, diagnosis, care or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

The Pre-Existing Condition Provision is waived for persons covered under this Plan prior to January 1, 2004.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the earliest of the following:

- 12 consecutive months from the Covered Person's Enrollment Date.

Benefits will then be payable for Covered Expenses Incurred for a Pre-Existing Condition after such period of time, reduced by Creditable Coverage as described below.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- Any person who, on the Enrollment Date, had 12 consecutive months of Creditable Coverage.
- Pregnancy, including complications.
- Pre-existing does not apply to prescriptions dispensed at a retail pharmacy, mail order pharmacy, or through a specialty pharmacy vendor.
- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.
- Treatment recommendations made prior to the six consecutive month period before the Enrollment Date when the Covered Person did not act upon the recommendation.

Effective: 01-01-2009

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION TIME PERIOD (Creditable Coverage)

If on the Enrollment Date, a Covered Person has less than 12 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies.

Creditable Coverage means that You had coverage under a group health plan, health insurance policy, Medicare or any one of several other health plans as described in the Glossary of Terms section of this document, and Your coverage was not interrupted by a Significant Break in Coverage.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-Existing Condition exclusion time period. Waiting Periods will not count towards a Significant Break in Coverage. In addition, the days between the date an individual loses health care coverage and the first day of the second COBRA election period under the Trade Act of 2002 will not count towards a Significant Break in Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the person's prior employer or insurance company as soon as possible. If You are having difficulty getting this, contact Your Human Resources or Personnel office for assistance.

It is the Covered Persons responsibility to submit their Certificate of Creditable Coverage to:

UMR
ENROLLMENT SERVICES
PO BOX 8052
WAUSAU WI 54402-8052

In addition, Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

EMPLOYEE BENEFITS CORPORATION
1350 DEMING WAY STE 200
CLIENT LIAISON
MIDDLETON, WI 53562-3536

You are encouraged to keep these Certificates in a safe place in case You get coverage under another health plan that has a pre-existing condition exclusion provision. By proving that You had prior Creditable Coverage, You may be able to have the pre-existing condition exclusion period reduced or eliminated.

YOUR RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If You feel that a determination of the pre-existing condition exclusion (PCE) period is incorrect, You may submit a written request for the review.

Send Your request to:

UMR
ENROLLMENT SERVICES
PO BOX 8052
WAUSAU WI 54402-8052

Your written request must be made within 60 days from the date of the notice. However, if Your request is based on additional evidence that shows that You had more Creditable Coverage than recognized originally, You may take longer.

Your written request should state the reasons that You believe the original determination is incorrect and include any additional facts that support Your position. You should submit any additional evidence that shows that You had more Creditable Coverage.

Your request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, You will be notified. You will be notified in writing of the decision on Your request if You submit additional evidence to consider or if the original Determination of PCE period is modified. If You do not receive notice of a decision within 60 calendar days after You submit the request, this means that the original decision was upheld.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

COBRA CONTINUATION OF COVERAGE

Effective: 01-01-2005

Important. Read this entire provision to understand Your COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides You with general notice of Your rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You as required.

The COBRA Administrator for this Plan is: Employee Benefits Corporation

INTRODUCTION

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

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

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

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18 month period of COBRA continuation coverage can be extended. See the section below entitled "Your Right to Extend Coverage" for more information.)

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from your spouse	up to 36 months

The Dependent children of an Employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, Your spouse and Dependent children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this can be a Qualifying Event. If it results in the Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

COBRA NOTICE PROCEDURES

ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

Effective: 01-01-2010

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify Your COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred.

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

EMPLOYEE BENEFITS CORPORATION
1350 DEMING WAY STE 200
CLIENT LIAISON
MIDDLETON WI 53562-3536

Customer service phone # is 800-346-2126
Fax: 806-831-4790
Website is www.ebcflex.com

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice when coverage terminates due to Qualifying Events that are the employee's termination of employment or reduction in hours, death of the employee, or the employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

You must give notice in the case of other Qualifying Events that are divorce or legal separation of the employee and a spouse, a dependent child ceasing to be covered under a plan, or a second Qualifying Event. The covered employee or Qualified Beneficiary must provide written notice to Your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

Once You have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

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

MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

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

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

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive on or after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group health coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

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

If Your employer offers annual enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

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

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however You will receive specific payment information including due dates, when You become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

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

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

YOUR NOTICE OBLIGATIONS WHILE ON COBRA

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

In addition, after any of the following events occur, written notice to the COBRA Administrator is **required within 30 calendar days of:**

- The date any Qualified Beneficiary gets married. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.

- The date a child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group health plan.

- The date the COBRA Administrator or the Plan Administrator requests additional information from You. You must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent child no longer being a Dependent as defined in the Plan.

- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent child of the covered Retired Employee can continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): In the event that You are determined by the Social Security Administration to be disabled, You may be eligible for up to 29 months of COBRA continuation coverage.

You must give the COBRA Administrator the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent children if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent. These events will only lead to the extension when the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

You must provide the notice of a second Qualifying Event within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

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

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

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If You Are Thinking Of Declining COBRA Continuation Coverage)

If You think You might need to get an **individual health insurance policy** soon, then electing COBRA continuation coverage now may protect some of Your rights. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, You must elect COBRA continuation coverage under this Plan and maintain it (by paying the cost of coverage) for the duration of Your COBRA continuation period. In the event that You need an individual health insurance policy, You must apply for coverage with an individual insurance carrier after You have exhausted Your COBRA continuation coverage and before You have a 63-day break in coverage.

If You think You will be getting **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if You have less than a 63-day break in health coverage (Creditable Coverage).

HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC)

The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance. Trade adjustment assistance is generally available to only a limited group of individuals who have lost their jobs or suffered a reduction in hours as a result of import competition or shifts of production to other countries. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/2002act_index.cfm.

Special COBRA rights apply to certain Employees who are eligible for the health coverage tax credit. These Employees are entitled to a second opportunity to elect COBRA coverage during a special second election period (if the Employee did not elect COBRA coverage already). The special second COBRA election period lasts 60 days or less, beginning on the first day of the month in which the Employee becomes an eligible HCTC recipient, but the election must also be made within six months after the initial loss of group health coverage. As a result, if the Employee finds out that he or she is eligible for this program with fewer than 60 days remaining in the six month period after initial loss of group health coverage, then this second election period will be less than 60 days. The Employee must send the COBRA Administrator a copy of the confirmation letter from HCTC or the State Workforce Agency, stating the effective date of eligibility under this program.

COBRA coverage elected during the special second election period is not retroactive. Coverage begins on the date that the special second election period begins, and the maximum COBRA coverage period will end on the same day it would have ended if COBRA coverage had been elected during the regular 60-day election period. There is no retroactive coverage for the gap period from the initial Loss of Coverage to the first day of the special second election period. For example, if an Employee's coverage ends on June 30 due to termination of employment, and the Employee elects COBRA coverage during a second 60-day election period that begins on November 1, the person would have no coverage from July 1 to October 31. COBRA coverage would start on November 1 and would end 14 months later because the maximum COBRA coverage period would expire 18 months from Loss of Coverage due to termination of employment. For purposes of Pre-Existing Condition exclusions, the Plan will not count any days between the initial loss of group health coverage and the first day of the special second election period as part of a 63-day Significant Break in Coverage.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

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

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Effective: 01-01-2006

INTRODUCTION

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

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

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

USERRA NOTICE AND ELECTION

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

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENT

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

PROVIDER NETWORK

Applies to Benefit Plan(s) 001 EPO

Effective: 01-01-2013

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. In all cases the network contract determines what the Plan will consider as a Covered Expense. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  0L – UnitedHealthcare Choice Plus

- **For Transplant Services at a Designated Transplant Facility, the Network is:**

  SunExcel

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are not subject to the Usual and Customary charge limitations. The following may apply:

- Covered Services provided by a radiologist, anesthesiologist, or pathologist will be payable at the In-Network level of benefits when rendered by an Out-of-Network provider when at an In-Network Hospital or referred by an In-Network Physician.
- **Out-of-Area, Emergency Care @ Out-of-Network Providers** is covered for conditions that a reasonably prudent layperson considers life or limb threatening.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

PROVIDER NETWORK

Applies to Benefit Plan(s) 003 PPO and 005 High Deductible

Effective: 01-01-2013

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. In all cases the network contract determines what the Plan will consider as a Covered Expense. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  0L – UnitedHealthcare Choice Plus

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  ZM – Multiplan Shared Savings

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

- **For Transplant Services at a Designated Transplant Facility, the Network is:**

  SunExcel

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are not subject to the Usual and Customary charge limitations. The following may apply:

- Covered Services provided by a radiologist, anesthesiologist, or pathologist will be payable at the In-Network level of benefits when rendered by an Out-of-Network provider when at an In-Network Hospital or referred by an In-Network Physician.
- Covered Services provided by an Emergency room Physician will be payable at the In-Network level of benefits when provided at an In-Network Hospital or referred by an In-Network Physician.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

COVERED MEDICAL BENEFITS

Effective: 01-01-2013

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

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

1. **Acupuncture Treatment and/or Assessment by a Qualified acupuncturist or Doctor of Oriental Medicine (D.O.M).**

2. **Allergy Testing and Treatment.**

3. **Alopecia:** Scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

4. **Ambulance Transportation:** Medically Necessary ground and air transportation to the nearest medically appropriate Hospital.

5. **Anesthetics** and their administration.

6. **Artificial Limbs, Eyes, and Larynx** when Medical Necessity is met for Activities of Daily Living, as a result of an Illness or Injury.

7. **Autism Services:** Limited treatment, consisting of:

   - Therapy to develop interactive skills and skills necessary to perform the significant Activities of Daily Living (eating, dressing, walking, bathing, toileting and communicating). The therapy must be ordered by a licensed medical provider. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Plan Administrator and updated annually with a report on the patient's condition, progress and future treatment plans. The provider must submit an evaluation every six months including objective evidence of progression towards goals.
   - Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child.
   - Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or Legal Guardian of an autistic individual to teach the principles and practical applications of behavior modification.
   - Autism ABA Therapy, for children younger than age 19, the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, incuding the use of observation, measurement and functional analysis of the relationship between environment and behavior. Services must be Medically Necessary.

8. **Braces, supports, trusses, and casts.**

9. **Breast Pumps.**

10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

12. **Cardiac Rehabilitation:**

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is Outpatient. Services generally begin within 30 days after discharge from the Hospital.

13. **Chiropractic Treatment** by a Qualified chiropractor or licensed Osteopath.

14. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes oral surgery and pregraft palatal expander when Medically Necessary.

15. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at a United Resource Transplant Network (URN) facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

16. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription oral contraceptives that a Covered Person self-administers will be processed under the Prescription Benefits section of this document. Prescription contraceptives that require a Physician to administer a hormone shot, patch, or insert a device will be processed under the Covered Medical Benefits in this SPD.

17. **Cornea transplants** are payable the same as any other Illness subject to the covered benefits provision of this Plan.

18. **Crutches** (the lesser of rental or purchase price).

19. **Dental and Oral Surgery:**
    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident, excluding implants.
    - Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the Hospital if the covered person is a child under five, or is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental care treatment.
    - Excision of completely unerupted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitus.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery and grafting) to treat gingivitis or periodontitis.
    - Apicoectomy (the excision of the tooth root without the extraction of the entire tooth).
    - Excision of exostosis of jaws and hard palate.
    - Alveolectormy (for fitting of dentures).

20. **Diabetes Treatment:** Charges incurred for the treatment of diabetes, diabetic self-management education programs, and the use of an insulin infusion pump or other equipment or supplies, including insulin are paid the same as any other Illness.

21. **Diet Counseling and Education** for Covered Person diagnosed with prediabetes, diabetes, congestive heart failure, hypercholesterolemia, and eating disorders (anorexia nervosa, bulimia, & pica.), celiac disease, crohn's disease, hypertension, liver disease, malabsorption syndrome, metabolic syndrome, morbid obesity, multiple or severe food allergies, nutritional deficiencies, renal failure, & ulcerative colitis. In order to be eligible for coverage, services must be provided by a Certified Diabetic Educator or a Certified Dietician and services must be provided at a Physician's office, a hospital, or a specialized treatment facility as defined by the Plan.

22. **Drugs** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's prescription.

23. **Durable Medical Equipment:** The lesser of the rental or purchase price of wheelchairs, hospital-type beds, oxygen equipment (including oxygen) and other Durable Medical Equipment, subject to Medicare Guidelines and the following:

    - The equipment is subject to review under the Utilization Management Provision of this Plan, if applicable.
    - The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and
    - The equipment will be provided on a rental basis, however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item; and
    - Benefits will be limited to standard models, as determined by the Plan; and
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and
    - If the equipment is purchased, benefits may be payable for subsequent repairs or replacement only if required:
        - due to the growth or development of a Dependent child;
        - when necessary because of a change in the Covered Person's physical condition; or
        - because of deterioration caused from normal wear and tear.

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

24. **Extended Care Facility Services:** Must be certified in advance. (Refer to the Utilization Management Section)

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

25. **Eye Diseases:** Protective lenses following a cataract operation.

26. **Foot Orthotics** Physician prescribed custom made appliances.

27. **Genetic counseling** or testing (including such procedures as amniocentesis) based on Medical Necessity.

28. **Hearing Deficit Services** include:

    - Exams, tests, services and supplies for other than preventive care, to diagnose and treat a medical condition.
    - Purchase and fitting of hearing aid.
    - Cochlear implants.

29. **Home Health Care Services:** (Refer to Home Health Care section).

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

    - **Assessment:** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care:** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
    - **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within six months of death.

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

31. **Hospital Services (includes Inpatient services, ambulatory surgery centers and Birthing Centers):**

    - Semi-Private Room and Board. For network charges, this rate is based on networking repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only when Medically Necessary.
    - Intensive Care Unit Room and Board.
    - Miscellaneous and ancillary services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

32. **Hospital Services (Outpatient).**

33. **Immunizations:** the following are covered:

    - HIB vaccine
    - HIB vaccine, PRP-OMP
    - Flu vaccine
    - Flu mist
    - D,T, AP Immunization DT Vaccine
    - Mumps Immunization
    - Rubella Immunization
    - Measles-rubella Immunization
    - Poliomyelitis Immunization
    - TD Vaccine
    - Hepatitis B Vaccine
    - Hepatitis B/HIB Vaccine
    - Tdap
    - HerpesZoster/Zostavax (A single dose for adults age 60 and over, once per lifetime)
    - HIB vaccine, PRP-D
    - HIB vaccine, PRP-T
    - Pneumococcal vaccine
    - DTP ImmunizationTetanus Immunization
    - Measles Immunization
    - MMR virus immunization
    - Combined Vaccine
    - Chicken pox vaccine
    - Diphtheria Immunization
    - Meningitis
    - Hepatitis A – Pediatric only to age 7
    - Rotavirus
    - HPV (Human Papillomavirus)

    Please refer to Exclusions to verify any possible exclusions.

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

35. **Infertility:** Diagnostic services including artificial insemination when done Invivo.

36. **Insulin Pump** if Medically Necessary.

37. **Laboratory Tests** for covered benefits

Effective: 01-01-2013

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

    - Prenatal and postnatal care.
    - Hospital room and board.
    - Obstetrical fees for routine prenatal care.
    - Vaginal delivery or Cesarean section.
    - Diagnostic testing (such as ultrasound and amniocentesis) when Medically Necessary.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Services of a Midwife.

39. **Mental Health Treatment (Refer to Mental Health section).**

40. **Morbid Obesity Treatment:** Tests or treatment that are determined to meet Medical Necessity and be appropriate for an individual's Morbid Obesity condition.

    - Gastric or intestinal bypasses, limited to one per lifetime.

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

41. **Nursery and Newborn Expenses Including Circumcision**, are covered for natural (biological) children of all Covered Persons.

    If a newborn has an Illness, suffers Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other Covered Expense if coverage is in effect for the baby.

42. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplemental feedings, over-the-counter nutritional and electrolyte supplements supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

43. **Orthognathic, Prognathic and Maxillofacial Surgery** when Medically Necessary.

44. **Oxygen and its Administration.**

45. **Physician Services** for covered benefits.

46. **Preventive / Routine Care** as listed under the Schedule of Benefits.

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

    - Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- Well-woman preventive care visit(s) for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus; and
  - Screening and counseling for interpersonal and domestic violence.

  Please visit the following links for additional information:

  http://www.healthcare.gov/law/resources/regulations/prevention
  or
  http://www.hrsa.gov/womensguidelines/]

Bone Density, Mammograms and Colonoscopies are covered for family history (paid according to normal Plan benefits).

47. **Radiation Therapy and Chemotherapy.**

48. **Radiology and Pathology** interpretation charges.

49. **Pharmacological Medical Case Management** (Medication management and lab charges).

50. **Reconstructive Surgery:**

    - Following a mastectomy (Women's Health and Cancer Rights Act)
      The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore bodily function and correct deformity resulting from a congenital illness or anomaly, accident, or from infection or other disease of the involved part.

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

52. **Sterilizations (Voluntary).**

53. **Substance Abuse Services** (Refer to Substance Abuse section).

54. **Surgery and Assistant Surgeon Services** if Medically Necessary. For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure, and fifty percent (50%) of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

55. **Temporomandibular Joint Disorder (TMJ) Services.** Benefits will be provided for:

- Surgical treatment of TMJ (Surgical treatment is covered same as any other Illness).
- Diagnostic services if Medically Necessary.
- Non-surgical treatment if medically necessary (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

TMJ shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly. This does not cover orthodontic services.

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

- **Occupational therapy** from a qualified, licensed *practitioner* received under the supervision of an attending *Physician* to restore fine motor skills of the upper extremities after an *Illness*, *Accident* or *surgery*. Benefits end once treatment is for Maintenance Therapy.
- **Physical therapy** from a qualified licensed practitioner received under supervision of an attending physician to restore motor functions needed for activities of daily living. Benefits end once treatment is for Maintenance Therapy.
- **Speech therapy** from a qualified licensed practitioner to restore speech loss due to an Illness, Injury, or surgical procedure. If the loss of speech is due to a birth defect, any required corrective surgery must have been performed prior to the therapy. Benefits end once treatment is for Maintenance Therapy.
- Respiratory therapy by a Qualified respiratory therapist.
- Aquatic therapy by a Qualified physical therapist or a Qualified aquatic therapist (AT).
- Massage therapy by a Qualified chiropractor or physical therapist.

This Plan does not cover services that should legally be provided by a school.

57. **Transplant Services** (Refer to Transplant section).

58. **Wigs, toupees, hairpieces** for hair loss due to cancer treatment or related to a medical condition.

59. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Effective: 01-01-2012

Home Health Care services are provided for patients who are unable to leave their home. Please refer to the Utilization Management Section for more details. Covered services can include:

- Home visits that are in lieu of visits to the Provider's office, and that do not exceed the Usual and Customary charge to perform the same service in a Provider's office.
- Intermittent Nurse Services. Benefits paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing Intermittent Nurse Services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

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

Effective: 01-01-2013

This coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. This coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

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

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

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

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

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

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

BENEFITS

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

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

COVERED EXPENSES

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

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

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

The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or Injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

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

SECOND OPINION

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

TRANSPLANT EXCLUSIONS

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

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational or Unproven.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFIT SUMMARY

The Prescription Drug Benefit is administered by Express Scripts
(Medco is now a part of the Express Scripts family of pharmacies.)

Effective: 01-01-2013

INTRODUCTION

This Prescription Drug Benefit Summary is a part of the Plan and is subject to all terms and conditions of the Plan (as modified by this summary). You may request a copy of the Plan from the Plan Administrator. This summary updates the Plan by clarifying, adding to and/or replacing the provisions described therein. Any terms and conditions of the Plan that are not specifically modified by this summary have not been changed and thus remain in full force and effect. If you have any questions about the Prescription Drug Program or this summary, please contact the Plan Administrator.

This is a Prescription Drug Program (the "Program") intended to cover the Usual and Customary (U&C) Charges for Prescription Drugs under the Marquette University plan (the "Plan"). Prescription Drug Benefits are provided to you under the Program as part of your medical benefit under the Plan. If you choose to not enroll for medical coverage, you will not be covered by this Program. The Program is part of the Plan and the Summary Plan Description.

Under the Program, if you get your prescription filled at a Network Pharmacy, you present your identification card and pay the applicable deductible and/or the applicable coinsurance. There are no claim forms to fill out. To find out whether your pharmacy is in this network, contact Express Scripts by calling 800.711.0917 or visiting Express-Scripts.com.

In addition, the Program includes the ***Medco Pharmacy***® mail-order pharmacy service to use when obtaining maintenance (long-term) medications. (The **Medco Pharmacy** is now a part of the Express Scripts family of pharmacies.) You may save money by using mail order to fill your maintenance drugs, such as those prescribed for diabetes, high blood pressure or asthma. You can receive up to a 90-day supply of medication through the **Medco Pharmacy.** You'll pay the applicable deductible and/or the applicable coinsurance each time you get a prescription filled.

DEFINITIONS

A **Brand-Name Drug (Brand Drug)** is a medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make it. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

Coinsurance is a cost-sharing requirement wherein the Covered Person assumes a portion or percentage of the costs of Prescription Drugs. The Covered Person is responsible for paying any Coinsurance amounts, according to a fixed percentage.

A **Coverage Review** is the process of obtaining approval for certain Prescription Drugs prior to dispensing, per the Plan. This approval is to be obtained from Express Scripts by the prescribing physician or the pharmacist. The list of Prescription Drugs requiring a Coverage Review is subject to periodic review and modification by the Plan and can be obtained by calling 800.711.0917 or visiting Express-Scripts.com.

Deductible refers to the individual and family prescription drug deductible amounts as shown on the Prescription Drug Schedule of Benefits. You are responsible for paying the deductible before any benefits will be paid under this prescription drug plan. After the deductible has been met, the Plan will pay the remaining Covered Expenses at the percentage shown on the Schedule of Benefits for the remainder of the calendar year.

An **Excluded Drug** is a Prescription Drug that is not covered under the Plan.

Experimental, Investigational or **Unproven** describes a medication, product or device that the Plan Administrator, in the exercise of its discretion, determines does not abide by accepted medical practice under the standards of a reasonably substantial, qualified, responsible and relevant segment of the medical community, after taking into account the requirements for Medically Necessary care and treatment. The Plan Administrator shall determine that a medication, product or device is Experimental, Investigational or Unproven to the extent that it has not been approved by the Food and Drug Administration. The decision of the Plan Administrator in this regard shall be made in its discretion, in accordance with this definition, and shall be final and binding on the Covered Person and all other interested persons.

A **Formulary** is a comprehensive list of drugs used by plan sponsors to highlight preferred products. Products are selected on the basis of safety, efficacy and cost.

An FDA approved **Generic Drug** is a medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. FDA approved generic medications may differ in color, size or shape, but the Food and Drug Administration requires that they be of the same strength, purity, and quality as their brand-name counterparts. A generic medication can be produced once the manufacturer of the brand-name medication is required to allow other manufacturers the opportunity to make it.

Medically Necessary or **Medical Necessity** refers to services or supplies that meet the following tests: They are recommended or approved by a licensed Healthcare Provider; they are appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they could not have been omitted without adversely affecting the Covered Person's condition; they are not primarily for the convenience of the Covered Person or the service provider; they are not Experimental, Investigational or Unproven; they are the most appropriate level or supply of service that can safely be provided.

The Plan Administrator or its agent shall determine, in its discretion, whether a service or supply is Medically Necessary and, in this respect, may consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid or other government-financed programs, and peer-reviewed literature. Although a Healthcare Provider may have prescribed or recommended a service or supply, such service or supply may not be Medically Necessary within this definition.

A **Network Pharmacy** is a pharmacy that has (1) entered into an agreement with Express Scripts or its designee to provide Prescription Drugs to Covered Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs and (3) has been designated by Express Scripts as a Network Pharmacy. A Network Pharmacy can be either retail or the **Medco Pharmacy.** A list of Network Pharmacies that provide Prescription Drug coverage to Covered Persons may be obtained by calling 800.711.0917 or visiting Express-Scripts.com.

A **Non-network Pharmacy** is a pharmacy that is not a Network Pharmacy.

A **Prescription Drug** is a medication, product or device that has been defined by the Food and Drug Administration that, under federal or state law, can be dispensed only pursuant to a Prescription Order or Refill and is required to be labeled "Caution: Federal Law prohibits dispensing without a prescription."

Prescription Drug Cost is calculated at the Express Scripts contracted reimbursement rate, including any sales tax, with the Network Pharmacy where a Prescription Drug is dispensed.

Prescription Order or **Refill** means the directive to dispense a Prescription Drug issued by a duly licensed Healthcare Provider legally authorized to write such a directive while acting in the scope of his or her license.

A **Specialty Pharmacy** is a dedicated pharmacy offering a broad spectrum of prescription medicines and integrated clinical services to patients on long-term therapies to support the treatment of complex, chronic diseases. Specialty prescriptions may be filled through the Express Scripts Specialty pharmacy. Certain Specialty medications must be filled through the Express Scripts Specialty Pharmacy. Review the Specialty Pharmacy Program section found later in this document for more details.

Step Therapy is a program that encourages the use of generics and lower-cost, alternative preferred brands. Under step therapy, a patient may first have to try a lower-cost drug to see if it produces effective results. If the clinical response is unsatisfactory, the patient may proceed to more expensive therapy that is covered by the plan.

The **Usual and Customary Charge** is the price that a pharmacy provider would have charged for a prescription on the date of service, if the member was a cash customer (i.e., the amount usually charged for pharmacy services). It includes all applicable discounts, such as senior citizen or promotional discounts.

PRESCRIPTION DRUG BENEFIT

Benefits are payable for the Usual and Customary Charge for outpatient Prescription Drugs unless specifically excluded under the Benefit Limitations and Exclusions or Excluded Drugs sections of this summary. The Prescription Drugs must be prescribed for:

- Medically Necessary treatment of an accidental Injury, Illness, or pregnancy.

Certain Prescription Drugs require a Coverage Review by a pharmacist or physician. Contact Express Scripts if you would like a list of the medications that require a coverage review as deemed by your plan.

The Covered Person must be covered under this Prescription Drug Program when the prescription is filled.

Identification Card

When you enroll in a medical plan, you will receive an identification card that includes the Express Scripts logo. When you present your identification card to a Network Pharmacy, the Network Pharmacy will fill your Prescription Order or Refill pursuant to the terms of its agreement with Express Scripts and your Plan Sponsor's schedule of benefits. To obtain an identification card for this Prescription Drug Program, call Customer Service at UMR at 800.826.9781 or online at www.UMR.com

Formulary Status

To find out the Formulary status of a medication, call 800.711.0917 or visit Express-Scripts.com.

Deductible/Coinsurance

Benefits under this Prescription Drug Program are subject to a deductible, coinsurance, annual maximums and Lifetime Maximum Benefit limits set forth by the Plan. Your prescription drug plan will follow whichever medical plan you have elected, whether Basic or Select. Your Prescription Drug Benefits are subject to the following Network Pharmacy Benefits:

Effective: 01-01-2012

EPO, PPO and High Deductible Plans	
Prescription Drug Annual Deductible	$75 individual (max. of $150 per family)
Prescription Drug Annual Out-of-pocket maximum. (deductible not included)	Out-of-pocket maximum per individual is $1,500 per individual, $3,000 per family. If you reach the out-of-pocket maximum, the Plan pays 100% of the cost of prescriptions for the remainder of the year. All other plan provisions apply.

Retail Network Pharmacy	
Generic Drug	After the deductible has been satisfied, the plan pays 90% for generic prescriptions (30-day supply) and you are responsible for 10% of the generic cost.
Formulary Brand Drug	After the deductible has been satisfied, the plan pays 70% for formulary brand prescriptions (30-day supply) and you are responsible for 30% of the formulary brand cost.
Non-formulary Brand Drug	After the deductible has been satisfied, the plan pays 60% for non-formulary brand prescriptions (30-day supply) and you are responsible for 40% of the non-formulary brand cost.
Medco Pharmacy	
Generic Drug	After the deductible has been satisfied, the plan pays 90% for generic prescriptions (90-day supply) and you are responsible for 10% of the generic cost.
Formulary Brand Drug	After the deductible has been satisfied, the plan pays 70% for formulary brand prescriptions (90-day supply) and you are responsible for 30% of the formulary brand cost.
Non-formulary Brand Drug	After the deductible has been satisfied, the plan pays 60% for non-formulary brand prescriptions (90-day supply) and you are responsible for 40% of the non-formulary brand cost.

Note: If you go to a retail pharmacy that is not part of the Express Scripts network, you must pay the full cost of the prescription. Complete a direct reimbursement claim form and submit it to Express Scripts. You will be reimbursed the amount that the medication would have cost your plan at a Network pharmacy, minus the applicable deductible and coinsurance that you would have paid.

Effective: 01-01-2011

Smoking-Cessation Products

- Coverage is limited to persons age 18 years and older at a $0 copayment.
- A prescription from a doctor is required for Over-the-Counter products.
- Nicotine replacement products and *Zyban*® for a 3-month treatment cycle within a 12-month period.
- Chantix® is for a 6-month treatment cycle within a 12-month period.

Following is a chart of the products:

Over-the-Counter Products:	**Tier**	**Copayment**
➢ Nicotine transdermal systems (Patches)	Generic	$0
7mg, 11mg, 14mg, 21mg, 22mg/24 hour		
➢ Nicotine polacrilex 2mg or 4mg gum	Generic	$0
Nicorette®	Brand	$0
➢ Nicotine polacrilex 2mg or 4mg lozenge	Generic	$0
Commit®	Brand	$0
➢ *Nicotrol*® NS nasal spray	Brand	$0
➢ *Nicotrol*® Inhaler	Brand	$0
Prescription Medications: Tier Copayment	**Tier**	**Copayment**
➢ Bupropion 150mg tablets	Generic	$0
Zyban®	Brand	$0
➢ Varenicline tablets 0.5 mg or 1 mg tablets	Generic	$0
Chantix® tablets	Brand	$0

Specialty Pharmacy

Certain outpatient prescriptions for specialty medications that are used for the treatment of the following medical conditions must be filled through the Express Scripts Specialty Pharmacy, including but not limited to the following.

- Allergic Asthma (e.g., *Xolair*®)
- Chronic Granulomatous Disease (e.g., *Actimmune*®)
- Gaucher's Disease (e.g., *Cerezyme*®)
- Growth Hormone Deficiency (e.g., *Genotropin*®)
- Hemophilia (e.g., *Advate*®)
- HIV wasting (e.g., *Serostim*®)
- Hepatitis C (e.g., *Pegasys*®)
- Immunodeficiency conditions (e.g., *Carimune*®)
- Multiple Sclerosis (e.g., *Avonex*®)
- Psoriasis (e.g., *Raptiva*®)
- Pulmonary Arterial Hypertension (e.g., *Tracleer*®)
- Respiratory Syncytial Virus (RSV) (e.g., *Synagis*®)

Additionally, certain outpatient self-administered specialty medications will be covered only through the prescription drug benefit.

The applicable deductible or coinsurance identified above will apply to Specialty Pharmacy prescriptions.

If a Covered Person does not show the identification card at the time that Prescription Drugs are obtained, the Covered Person will be required to pay the full cost of the Prescription Drug and submit a claim to Express Scripts for reimbursement. Reimbursement is paid based on the benefits outlined above.

Medco Pharmacy

A mail-order pharmacy service, called the **Medco Pharmacy,** is provided for your convenience when obtaining maintenance drugs. If you use the mail-order service, you will pay the applicable deductible and coinsurance as shown in the table above.

There is no coverage for Prescription Drugs dispensed by any mail-order service other than the **Medco Pharmacy.**

The **Medco Pharmacy** dispenses Generic Drugs whenever available unless indicated otherwise ("dispense as written," or DAW) by the prescribing physician, Express Scripts may contact the prescribing physician to request substitution of a Generic Drug.

To order a Prescription Drug from the **Medco Pharmacy,** follow the instructions set forth below:

- Log on to Express-Scripts.com to obtain a **Medco Pharmacy** Mail-Order Form.
- Place all new Prescription Orders or Refills together with the completed form and your payment in an envelope.
- Checks, money orders and credit cards are accepted.
- Mail completed form, applicable Copayments and Prescription Orders or Refills to:

EXPRESS SCRIPTS
PO BOX 650322
DALLAS TX 75265-0322

You can also get started using the **Medco Pharmacy** by having your doctor fax your prescription to Express Scripts. Provide your doctor your Member ID number (shown on your Express Scripts prescription ID card) and ask him or her to call **888.327.9791** for instructions on how to use our fax service. You will be billed later.

If you need additional help, call Member Services at 800.711.0917.

How to File a Paper Claim

To file a paper claim with Express Scripts to obtain a reimbursement from the Plan for any prescription that is paid in full at the time that it is filled, follow the instructions set forth below:

- Log on to Express-Scripts.com to obtain a Prescription Drug Reimbursement Form.
- Only use a claim form when you have paid a pharmacy's full price for a Prescription Drug order because:
  - The pharmacy does not accept your ID Card, or
  - You have not received your ID Card.
- You must complete a separate claim for each pharmacy used and for each Covered Person.
- You must submit claims within one year of date of purchase or as required by your Plan.
- Be sure your receipts are complete. In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
- The Covered Person should read the Acknowledgement notification carefully, then sign and date the form.
- Return the completed form and receipts to:

EXPRESS SCRIPTS
PO BOX 14711
LEXINGTON KY 40512

Claim Procedures

The Plan Administrator has delegated the authority to make Benefit determinations under the Plan with respect to this Prescription Drug Program to Express Scripts including, without limitation, factual determinations. Express Scripts shall consider the terms and provisions of the Plan (and this Program, which is part of the Plan), and shall have the power and discretion to interpret, construe and construct the Plan and this Program. All such determinations made by Express Scripts, whether in the case of an appeal from a claim denial or in the case of an initial Benefit determination that is not appealed, arising in connection with the administration, interpretation or application of the Plan and this Program, shall be conclusive and binding upon all persons.

The Plan Administrator has delegated to Express Scripts the right and power to administer and to interpret, construe and construct the terms and provisions of this Program, including, without limitation, correcting any error or defect, supplying any omission and reconciling any inconsistency.

If, due to errors in drafting, any provision of this Program does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. This Program may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan or this Program to the contrary.

No Prescription Drug Benefit shall be paid under the Plan unless a Covered Person has first submitted a written prescription for Benefits. A request for a prescription at a pharmacy shall not be treated as a claim under the terms of the Plan.

Appeal Procedures

Because the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to appeal a denial of Benefits in accordance with the claim procedures under ERISA. If you disagree with the denial of your claim and desire to request that the decision be reevaluated, you must file an appeal under the Plan within 30 days after receiving the denial notice. All appeals must be submitted in writing to Express Scripts. Your appeal should include a copy of the denial notice, a copy of the Explanation of Benefits, an explanation as to why the initial decision should be reversed, and a copy of any information that will support your request.

You shall have the opportunity to submit written comments, documents, records and other information relating to your claim. You may review or request copies (free of charge) of all documents, records and other information relevant to your claim. The appeal shall take into account all comments, documents, records and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim denial.

The appeal shall not afford deference to the initial denial and shall be conducted by a decision maker who is neither the individual who made the initial denial nor the subordinate of such decision maker. In deciding an appeal of a claim denial that is based in whole or in part on a medical judgment, the decision maker shall consult with a Healthcare Provider who has appropriate training and experience in the field of medicine involving the medical judgment. All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial shall be identified without regard to whether the advice was relied upon in making the decision on the claim. A Healthcare Provider engaged for purposes of consultation with respect to the appeal shall be an individual who is neither an individual who was consulted in connection with the initial denial nor the subordinate of such individual.
Express Scripts will respond to any appeal within a reasonable period of time but not later than 60 days from the date of receipt of your appeal. Express Scripts will provide you with written notice of the Plan's decision on appeal. The notification shall set forth in a manner calculated to be understood by you:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions upon which the determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for Benefits;
- A statement of your right to bring a civil action under Section 502(a) of ERISA;
- If the denial is based on:
  - An internal rule, guideline, protocol or other similar criterion, either the specific rule, guideline, protocol or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in deciding the appeal and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request; or
  - A Medical Necessity or Experimental, Investigational or Unproven or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

If your appeal is denied, you may request a second level of appeal through Express Scripts. The second-level appeal will be handled by an independent, outside source. The response time will be 30 days from the date of receipt of your appeal, subject to any applicable extensions under ERISA.

- Because your Plan is subject to ERISA, if all applicable appeals of your claim have been denied, you have the right to bring a civil action under Section 502(a) of ERISA to challenge the denials in court. You may not bring a civil action under ERISA before you complete the administrative appeal process described herein. Additionally, you and your Plan may have other voluntary alternative dispute resolution options, such as mediation, as may be described in the Plan.

Benefit Limitations and Exclusions

The Prescription Drug Program pays the highest benefits for Generic Drugs.

If a brand-name prescription is purchased and a generic equivalent is available, the plan will pay based on the generic drug cost. The covered person will be responsible for paying the difference in cost between the brand and the generic. If the covered person reaches the annual out-of-pocket maximum, the difference in cost between the brand and the generic will continue to be the covered person's responsibility.

Fertility prescription drugs are provided based on the benefit chart provided above. There is a $500 per family lifetime maximum benefit for fertility prescriptions. When the Plan has paid $500 toward fertility prescriptions, your family has reached its lifetime maximum. No prescription drug coverage for fertility services will be provided once the plan maximum has been reached.

For individuals taking proton pump inhibitors, the Plan requires the use of an alternative generic or preferred medication that has been shown to be equally effective in treating most patients. If the alternative medication does not prove to be effective, Express Scripts will work with your physician to switch to a more effective medication.

Specialty prescriptions to treat specific medical conditions must be filled through the Express Scripts Specialty Pharmacy. Supply limits will be based on the patient's condition and drug therapy recommendations.

The amount that the Plan pays for prescription drugs accumulates toward the $2 million lifetime maximum per individual under the Plan. See the medical plan Schedule of Benefits.

The limitations outlined in this summary are captured at a period of time. For the most up-to-date list of limitations, please call 800.711.0917.

Effective: 01-01-2011

Network Pharmacy

If the Prescription Drug is dispensed by a Network Pharmacy, the following limits apply. Up to a 30-day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by Express Scripts.

Medco Pharmacy

If the Prescription Drug is dispensed by the **Medco Pharmacy,** the supply limit is up to a 90-day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by Express Scripts. A list of current supply limits may be obtained from Express Scripts.

Coordination of Benefits

Benefits paid for Prescription Drugs will be subject to the coordination of benefits provision as outlined in the Summary Plan Description.

Excluded Drugs

The following are excluded from coverage unless specifically listed as a benefit under the "Covered Drugs" or "Benefit Limitations and Exclusions" sections.

- Non-federal Legend Drugs
- Non-systemic contraceptives, or devices
- Injectable medications (except as listed)
- Drugs used to treat impotency (except Yohimbine)
- Dental fluoride products
- Alcohol swabs
- *Glucowatch*/sensors
- *Mifeprex*
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e., *Rogaine*®, *Propecia*®) or for cosmetic purposes only (i.e., *Renova*®, *Vaniqa*®, *Tri-Luma*®, *Botox-Cosmetic*®, *Solage*®, *Avage*®, *Epiquin*®).
- Allergy Serums
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution—limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates on its premises—or allows to be operated on its premises—a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Any prescription dispensed prior to the covered persons effective date or after the termination date of coverage.
- Durable Medical Equipment, including but not limited to Peak Flow Meters and ostomy supplies.

- Prescription drugs or medicines in connection with sex transformation surgery, including sex hormones related to such surgery and prescription drugs or medicines in connection with treatment of sexual dysfunction not related to organic disease.
- Depigmentation products used for skin conditions requiring bleaching agent.
- Therapeutic devices or appliances, including support garments, and other non-medicinal substances, except those listed herein.

Coverage Review

- Appetite and Weight Loss Therapy
- Miscellaneous Dermatologicals (*Retin-A* and co-brands and *Tazorac*—all dosage forms) ages 36 years and older
- COX-2 Inhibitors (*Celebrex*)
- Preferred Drug Step Therapy—Proton Pump Inhibitors

Covered Drugs

The Plan may further be limited and excluded per the plan design.

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Insulin Needles and Syringes
- Non-insulin syringes
- Legend Vitamins
- Growth Hormones
- Legend Meclizine
- OTC diabetes supplies (except alcohol swabs or *Glucowatch*/sensors)
- Oral, transdermal, intervaginal or injectable contraceptives
- Yohimbine
- *Retin-A/Avita* through age 35
- *Tazorac* creams through age 35
- *Synagis* or *RespiGam*
- Self-injectables

MENTAL HEALTH PROVISION

Effective: 01-01-2012

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be meet the Medical Necessity for the treatment of mental Illness, subject to any Deductibles, Co-pays, coinsurance amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule or the negotiated rate.

COVERED BENEFITS

Covered Expenses are:

Inpatient Services: Subject to the following provisions:

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

- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.

- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified.

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

Outpatient Services: Subject to the following provisions:

- Be in-person at a doctor's office.

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident.

- Must be provided by:

  - A United States board eligible or board certified psychiatrist in the state where the treatment is provided.

  - An advanced practice nurse practitioner in behavioral health.

  - A therapist with a Ph.D or master's degree that denotes a specialty in behavioral health or mental health counseling.

  - A state licensed psychologist.

  - A state licensed Clinical Social Worker or certified Social Worker.

  - State Licensed Professional Counselor.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued coverage will be denied.
- Services for biofeedback are covered.

MENTAL HEALTH EXCLUSIONS (In addition to the General Exclusions discussed later):

- Treatment or care that is not considered necessary or appropriate, as determined by the Plan.
- Inpatient charges for the period of time when full, active treatment meeting the Medical Necessity for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this document.
- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.
- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories: organic psychotic disorders; personality disorders; sexual/gender identity disorders; behavior and impulse control disorders; or "V" codes.
- Services from a Social Worker with a Bachelor's degree.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY PROVISION

Effective: 01-01-2012

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays, coinsurance amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary charge or the negotiated rate as applicable.

COVERED BENEFITS

Covered Expenses are:

Inpatient Services: Subject to the following provisions:

- The Hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of substance abuse and chemical dependency. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person's condition must be treatable in an Inpatient facility.

- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

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

Outpatient Services: Subject to the following provisions:

- Be in person at a doctor's office; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by:

  - A United States board eligible or board certified psychiatrist in the state where the treatment is provided.

  - A therapist with a Ph.D or master's degree that denotes a specialty in psychiatry.

  - A state licensed psychologist.

  - A certified substance abuse counselor.

ADDITIONAL PROVISIONS AND BENEFITS:

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued coverage will be denied.

SUBSTANCE ABUSE EXCLUSIONS (In addition to the General Exclusions in this document):
The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active treatment meeting the Medical Necessity for the Covered Person's condition is not being provided.
- Inpatient treatment for intoxication without evidence or history of medical complications.
- Services, treatment or supplies related to addiction to or dependency on nicotine.

UTILIZATION MANAGEMENT
And Other Medical Management Services

Effective: 01-01-2012

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

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. For In-Network services, Your Physician or provider must call the phone number on the back of the Plan identification card to request prior authorization. For Out-of Network services, You are responsible for calling the Utilization Management Provider at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note for United Healthcare Choice Plus Provider Services: The Facility where care was provided must contact the Utilization Review Organization (see below) within 24 hours of admission, or the next business day for weekend/holiday admissions. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

For Purposes of Non-United Healthcare Choice Plus Providers and Out-of-Network Services: The Covered Person will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

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

UTILIZATION REVIEW ORGANIZATION

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

DEFINITIONS

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

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

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

UNITED HEALTHCARE CHOICE PLUS PROVIDER SERVICES REQUIRING ADMISSION PRIOR AUTHORIZATION

Hospitals and Extended Care Facilities are responsible for Admission Prior Authorization. Admission Prior Authorization applies to every admission to an acute care hospital or Extended Care Facility.

UNITED HEALTHCARE CHOICE PLUS PROVIDER SERVICES REQUIRING ADVANCE PRIOR AUTHORIZATION

The Physician, health care professionals, or ancillary provider must call the Utilization Review Organization for Advance Prior Authorization **before** providing services for the following:

- Orthopedic/Spine Surgeries (spinal surgeries, total knee replacements and total hip replacements)
- Organ and tissue transplants.
- Reconstructive/Potentially Cosmetic Procedures
- Bariatric Surgeries
- Congenital Heart Disease

UNITED HEALTHCARE CHOICE PLUS PROVIDERS, NON-UNITED HEALTHCARE CHOICE PLUS PROVIDERS AND OUT OF NETWORK SERVICES REQUIRING PRIOR AUTHORIZATION

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

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care, if exceeding 20 visits for the same diagnosis.
- Durable Medical Equipment over $1500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,500, including custom made braces/splints.
- All Inpatient or Outpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Inpatient stay for Long Term Acute Care (LTAC)

Outpatient Services for the following:

- Gastric Bypass
- Potential Cosmetic Procedures, e.g. blepharoplasty, rhinoplasty
- Sclerotherapy
- Selected Injectable Therapy, e.g. Synagis, Growth Hormone
- Uvulopalatopharyngoplasty (UPPP)
- Chemotherapy
- Acute Dialysis
- Outpatient Surgical Procedures outside the MD office
- All pediatric therapy PT/OT/ST. All children 16 & under – initial evaluation allowed without Prior Authorization. No additional sessions until approved by UMR
- Adult Speech Therapy
- Pulmonary rehab Therapy
- All other therapies (PT/OT/MH/SA, etc.) – if exceeding 24 visits for the same diagnosis (regardless of the number of providers)
- Infertility (in vitro fertilization is excluded)
- Neuromuscular Stimulator
- Electrical Bone Growth Stimulator
- High dollar injections – above $500 per dosage or month

- MRI
- MRA
- PET
- CT
- Nuclear Cardiology
- Orthognatic surgery
- Autism ABA Therapy

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

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION FOR SERVICES BY A UNITED HEALTHCARE CHOICE PLUS PROVIDER

- **Advance Prior Authorization**

  Failure on the part of the provider to obtain Advance Prior Authorization will result in a reimbursement reduction to that provider. You are not responsible for this amount.

- **Admission Prior Authorization**

  Failure by the facility to meet Admission Prior Authorization requirements will result in a reimbursement reduction to the provider. You are not responsible for this amount.

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

Even though a provider or facility complies with the Prior Authorization requirement and informs the Utilization Review Organization, it does not guarantee that this Plan will pay for the medical care. The Covered Person needs to be eligible for coverage on the date services were provided. In addition, coverage is also subject to all of the provisions described in this document.

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION FOR NON-UNITED HEALTHCARE CHOICE PLUS PROVIDERS AND FOR OUT-OF-NETWORK SERVICES

A non- Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $500 will be applied per admission if a Covered Person receives services but did not obtain the required Prior Authorization for:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment over $1500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,500.
- All Inpatient or Outpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Inpatient stay for Long Term Acute Care (LTAC)

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

Even though a Covered Person provides Prior Authorization to the Utilization Review Organization, it does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this document.

Medical Director Oversight. A UMR Care Management medical director supervises the entire concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine the best course of action and will reach out to the member's Physician for a peer-to-peer discussion, if necessary.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. These triggers include ICD-9 diagnosis codes, CPT codes, length-of-stay criteria and claims dollar thresholds, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

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

Other Medical Management Services provided by AURORA HEALTH CARE

Disease Management

You or a family member may be suffering from a major Illness associated with the chronic disease population segment. Care (Disease) Management is a series of special programs designed to help improve the health status and well-being of You or a family member suffering from a major Illness, and reduce hospitalization and emergency room costs. The goal of these programs is to provide: (a) integrated, patient/family-oriented and coordinated care for certain high prevalence, high cost, and impactable diagnoses, (b) guidelines for providers, patients, and families enabling You to become partners in health care decisions, and (c) a basis for measuring outcomes and comparing outcomes to best practice patterns.

Chronic Disease Management programs are available for many conditions including:

- Asthma
- Congestive heart failure
- Depression
- Diabetes mellitus
- CHF
- Cholesterol management
- Breast & cervical cancer screening
- Colorectal cancer screening

If You or a family member has any of the above medical conditions (diagnoses), You will be automatically enrolled in a Disease Management program.

Other Medical Management Services provided by UMR CARE MANAGEMENT

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to participate. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

COORDINATION OF BENEFITS

Effective: 01-01-2011

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

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

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

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details (below).
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

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

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – No-Fault State in this SPD for more details.

- The plan that covers the person as an employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- 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.

- If one or more plans cover the same person as a Dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. If the two plans do not agree on the order of benefits, this rule is ignored. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare. Payments from Medicare and this Plan will not exceed 100% of the charged amount, minus any Deductibles, Co-pays or coinsurance amounts that You need to pay.

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

Effective: 01-01-2013

The Plan has a right to subrogation and reimbursement.

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

The right to reimbursement means that if a third party causes or is alleged to have caused an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any covered benefit you received for that Illness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

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

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

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common-Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon our request, You will assign to us all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these subrogation provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party and filing suit in Your name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Effective: 01-01-2012

Exclusions, including complications from excluded items are not considered benefits under this Plan and will not be considered for payment.

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

1. **Abortions:** Unless a Physician states in writing that:
   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy.

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

3. **Alternative Treatment:** Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.

4. **Appointments Missed**: An appointment the Covered Person did not attend.

5. **Aquatic Therapy** unless provided by a Qualified physical therapist or Qualified aquatic therapist (AT).

6. **Assistance with Activities of Daily Living.**

7. **Assistant Surgeon services**, unless determined to meet Medical Necessity by the Plan.

8. **Auditory Integration.**

9. **Augmentation communication devices** and related instruction or therapy.

10. **Before and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends are not covered.

11. **Blood:** Blood donor expenses.

12. **Body Piercing** and/or subsequent complications resulting from that procedure.

13. **Cardiac rehabilitation** beyond Phase II.

14. **Chelation therapy,** except in the treatment of conditions considered to meet the Medical Necessity, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

15. **Close Relative:** Services performed by a Close Relative or by someone who ordinarily lives in the Covered Person's home.

16. **Complications** arising from any non-covered surgery, procedure, service, or treatment.

17. **Contraceptive Products and Counseling** unless covered elsewhere in this Plan.

18. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

19. **Counseling services** in connection with marriage, pastoral or financial counseling.

20. **Court-ordered:** Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of Driving While Intoxicated classes or other classes ordered by the court.

21. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this Criminal Activity took place.

22. **Custodial Care.**

23. **Dental**:

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or Drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for X-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

24. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions

25. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

26. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.

27. **Employment or Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

28. **Environmental devices**: Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

29. **Equestrian Therapy.**

30. **Examinations**: Examinations for employment, insurance, licensing or litigation purposes; or sports or recreational activity.

31. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment.

32. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

33. **Family Planning:** Consultation for family planning.

34. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

35. **Foot Care**: Routine foot care and removal of corns, calluses, toenails or subcutaneous tissue, except when care is prescribed by a Physician treating metabolic or peripheral vascular disease (example diabetes).

36. **Foreign Travel**: Foreign travel immunizations.

37. **Habilitative Services** including vocational or industrial rehabilitation services or work hardening.

38. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

39. **Hypnotism.**

40. **Invitro Fertilization.**

41. **Lamaze classes** or other child birth classes.

42. **Lasik Surgery** or similar surgery used to improve eye sight.

43. **Learning Disability:** Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

44. **Light box and light therapy.**

45. **Maintenance Therapy:** See Plan; Glossary of Terms.

46. **Mammoplasty or augmentation** unless covered elsewhere in this document.

47. **Massage therapy** unless provided by a Qualified chiropractor or physical therapist.

48. **Military:** A military related Illness or Injury to a Covered Person on active military duty.

49. **Nicotine:** Services, treatment or supplies related to addiction to or dependency on nicotine.

50. **No-Fault State:** Benefits are not payable under this Plan for any Illness/Injury received in an Accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under No-fault have been exhausted.

51. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards.

52. **Not Determined to Meet Medical Necessity**: Services, supplies, treatment, facilities or equipment which the Plan determines do not meet the guidelines for Medical Necessity.

53. **Nursery and newborn expenses** for grandchildren of covered employee or spouse.

54. **Over-the-counter medication**, products or supplies.

55. **Penalties** if required pre-authorization is not obtained.

56. **Personal Comfort**: Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

57. **Panniculectomy/Abdominoplasty** unless determined by the Plan to meet Medical Necessity.

58. **Prescription medication**, other than those administered while in the Hospital or Physician's office as part of treatment, unless benefits under the Prescription Drug Benefit Summary in this document.

59. **Prescription medication**: Take home drugs filled by a Hospital or Physician's office, unless benefits are provided under the Prescription Drug Benefit Summary in this document.

60. **Private duty nursing services.**

61. **Radial Keratotomy or Refractive Keratoplasty**: Radial keratotomy and other refractive keratoplasty procedures.

62. **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, unless covered elsewhere in this document.

63. **Return to Work/School**: Telephone consultations or completion of claim forms or forms necessary for the return to work or school.

64. **Reversal of Sterilization**: Procedures or treatments to reverse prior voluntary sterilization.

65. **Room and board fees** when surgery is performed other than at a Hospital or Surgery Center.

66. **Self-administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

67. **Sensory Integration.**

68. **Services at no Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

69. **Services Provided by a Close Relative.** See Glossary of Terms for the definition of Close Relative.

70. **Sex Therapy.**

71. **Sexual function:** Any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erectaid devices.

72. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

73. **Supplements:** All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements and related supplies including feeding tubes, pumps, bags and products.

74. **Surrogate motherhood** expenses.

75. **Taxes:** Sales taxes, shipping and handling.

76. **Telemedicine or telephone consultations.**

77. **Third Party Liabilities:** Any Covered Expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically include, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments, and homeowner's insurance.

78. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

79. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician including vaccines and immunizations related to work or travel, unless authorized in advance by the Plan.

80. **Usual and Customary Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge or the negotiated fee.

81. **Vision Care** unless covered elsewhere in this document.

82. **Vitamins, minerals and supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician and meet Medical Necessity.

83. **Vocational Testing, Evaluation and Counseling:** Vocational and educational services rendered primarily for training or education purposes.

84. **Warning Devices:** Warning devices, stethoscope, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring.

85. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

86. **Wigs, toupees, hairpieces**, hair implants or transplants or hair weaving, or any similar item for replacement of hair, unless benefits are provided elsewhere in this document.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced coinsurance level, with the Covered Person being responsible for a larger percentage of the total medical expense.

CLAIMS AND APPEAL PROCEDURES

Effective: 01-01-2012

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. UMR will normally send payment for Covered Expenses directly to the Covered Person's provider.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this document specifically require the person to call for prior authorization. Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or 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 his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

AUTHORIZED REPRESENTATIVE

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

If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Authorized Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below. The address for submitting medical claims is on the back of the group health identification card.

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

Effective: 01-01-2012

PROOF OF LOSS

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 180 days from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

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

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Coinsurance rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Covered Expenses.

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

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile. The U&C guidelines do not apply to In-network claims, which are governed by the network contract. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

Effective: 01-01-2012

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

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

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services do not meet Medical Necessity.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Coinsurance obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or negotiated rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

Effective: 01-01-2012

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in a plan.

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

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

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

- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

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

- Covered Persons who are not satisfied with the decision following the first appeal, have the right to appeal the denial a second time.
- Covered Persons or their Authorized Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Authorized Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Effective: 01-01-2012

Appeals should be sent within the prescribed time period as stated above to:

This Plan contracts with various companies to administer different parts of this Plan. Covered Persons who want to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. The names and addresses of the companies that the Plan contracts will include:

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

Send Pharmacy appeals to:
EXPRESS SCRIPTS
PO BOX 631850
IRVING TX 75063-0030
ATTN: ADMIN REVIEWS

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

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

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the medical necessity, but not later than 24 hours after the receipt of the claim by the Plan.

RIGHT TO EXTERNAL REVIEW

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

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services; or
- 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 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 or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

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

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, 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 qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

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

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

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

If there is any information or evidence 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 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 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.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

FRAUD

Effective: 01-01-2011

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

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

Covered Persons must:

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

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

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

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

OTHER FEDERAL PROVISIONS

Effective: 01-01-2011

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a 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 Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SUMMARY OF MATERIAL REDUCTIONS RULE

HIPAA requires group health plans to furnish each participant with a summary of any material reductions in covered benefits no later than 60 days after the adoption of the change.

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

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby employers will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent children in cases of adoption or placement for adoption as required by ERISA.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).
- Children's Health Insurance Program Reauthorization Act (CHIPRA).

STATEMENT OF ERISA RIGHTS

Effective: 01-01-2011

Covered Persons under this group health Plan, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

There will be a reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan if a Covered Person has Creditable Coverage from another plan. Covered Persons with Creditable Coverage from another plan should be provided a Certificate of Creditable Coverage free of charge, from the prior group health plan or health insurance issuer when coverage under the plan is lost, upon entitlement to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested by the Covered Person before losing coverage, or if requested by the Covered Person up to 24 months after losing coverage. Without evidence of Creditable Coverage, Covered Persons may be subject to a Pre-Existing Condition exclusion for 12 months if application is made when first eligible after a Covered Person's Enrollment Date in coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, the Plan Administrator should be contacted. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

Effective: 01-01-2006

The Plan Sponsor fully intends to maintain this Plan indefinitely, however the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Plan participants within 60 days following the adopted formal action that makes material changes to the Plan.

Your Rights if Plan is Amended or Terminated

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses incurred before You receive notice of termination.

The Plan will assume that You received the written amendment or termination letter from the Plan Administrator three days after the letter is mailed to You regarding the changes.

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

Distribution Of Assets Upon Termination Of Plan

Plan assets will be held for the exclusive purpose of providing benefits and defraying reasonable expenses, and will not inure to the benefit of the employer, except:

- If Plan assets consist of both participant contributions and employer contributions, the employer will determine which portion of the remaining assets is from the employer contributions and which portion is from participant contributions. The assets that are from participant contributions will be used to cover the cost of incurred Covered Expenses and reasonable expenses to administer the Plan. The portion of assets that are from employer contributions can be reverted to the employer.
- If all Plan assets are from employer contributions, the assets at the time of termination can revert to the employer, once incurred Plan expenses have been paid.

No Contract of Employment

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

GLOSSARY OF TERMS

Effective: 01-01-2012

Accident means an unexpected, unforeseen and unintended event.

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

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

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

Ambulance Transportation means professional ground or air Ambulance Transportation in an emergency situation or when deemed to meet Medical Necessity, which is:

- To the closest facility most able to provide the specialized treatment required; and

- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

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

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, Your Domestic Partner, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, Your domestic partner's children, step children and grandchildren.

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

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

Covered Expenses means any expense, or portion thereof, which is incurred as a result of receiving a covered benefit under this Plan.

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

Effective: 01-01-2012

Creditable Coverage means coverage an individual has under the following, as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A State health benefits risk pool;
- A State Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a State, the US government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.

Custodial Care means nonmedical care given to a Covered Person to assist primarily with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Disorder is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Disorders generally do not have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms.

Domestic Partnership means a relationship between an employee and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a domestic partner of, another person under either statutory or common law.
- They must share a common residence and common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

The employee and domestic partner must be registered with and recognized as domestic partners in the state in which they reside. In the case where an employee and his or her domestic partner reside in a state that does not have a registry, the employee and domestic partner must jointly sign an affidavit of Domestic Partnership.

Durable Medical Equipment is equipment which is designed for repeated use; is intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Emergency means a serious medical condition which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.

- For anyone who enrolls on a Special Enrollment date, the Enrollment Date is the first day of coverage.

Essential Health Benefits means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, etc.).

Expense Incurred means the charge for a service, treatment, supply or facility. The expense is considered to be incurred on the date the service or treatment is given, the supply is received or the facility is used.

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

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

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

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

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

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

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

Habilitative Services means services which are educational in scope and purpose and are rendered to develop, improve or accelerate functions that have never been present or are not present to the normal degree of a person of like age or sex.

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

For purposes of Home Health Care, Nurse Services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

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

Hospital means:

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

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

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

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

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

Injury means an act causing harm or damage to the body.

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

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

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

Lifetime Maximum Benefit means the maximum amount of covered benefits payable while a person is covered under this Plan. When the Lifetime Maximum Benefit is met, a Covered Person is no longer eligible for benefits under this Plan. Lifetime does not mean during the lifetime of the Covered Person.

Maintenance Therapy: Unless specifically mentioned otherwise in the Plan, the Plan does not provide benefits for medical services and supplies intended primarily to maintain a level of physical or mental function. Therapy is considered maintenance if there is no reasonable expectation that services will provide significant measurable improvement in the Covered Person's condition in a reasonable and generally predictable and finite period of time. This begins after the acute phase of an Illness or Injury has passed and the Covered Person's recovery has reached a plateau or only minimal improvement can be demonstrated. UMR Care Management's team reviews medical records and therapy treatment plans to make a determination regarding Maintenance Therapy.

Maximum Benefit means the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are incurred while the person is covered under the Plan.

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

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

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

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

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

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

Mentally Disabled means an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

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

Morbid Obesity means a Body Mass Index (BMI) that is greater than 35 kg/m2.

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

Ordinary Care means the degree of care, skill and diligence that a reasonable and prudent administrator would exercise in making a fair determination on a claim for benefits similar to the claim involved.

Orthotic Appliances means braces, splints and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

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

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), acupuncturist or doctor of oriental medicine (DOM), podiatry (DPM), dentistry (DDS), chiropractic (DC), a physician's assistant (PA), midwife, a certified nurse midwife (CNM) or a registered dietician. Primary Care Physician (PCP) for Mental Health and Substance Abuse are all providers except medical doctors.

Effective: 01-01-2012

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

Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within six consecutive months ending on the Enrollment Date.

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

Primary Care Physician means a family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician, a specialty physician's assistant (PAS) or obstetrician/gynecologist. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

Provider Directory means a list of the Participating Providers.

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

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, Accident, or Illness. It is generally performed to improve or restore function.

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

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

Specialist means a provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, or obstetricians/gynecologists.

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

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

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

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

Third Party Administrator (TPA) is a service provider hired by the Plan to process medical claims, provide medical management or perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan. The Third Party Administrator for this Plan is UMR.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability, conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

    - Organic psychotic disorders, or
    - Personality disorders, or
    - Sexual/gender identity disorders, or
    - Behavior and impulse control disorders, or
    - “V” codes.

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

The Plan means MARQUETTE UNIVERSITY.

You, Your means the Employee.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

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

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

This Plan shall Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose Your PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

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

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of Your PHI:

- The Plan Sponsor will only Use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

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

Associate Vice President of Human Resources, Benefits Manager, Benefits Specialist and Benefits Analyst

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

DEFINITIONS

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

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

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

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

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

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

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

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

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;

- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

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

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

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

Plan Sponsor means Your employer.

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

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

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

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

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