WALWORTH COUNTY
HEALTH PLAN

Tier 2

Restated and Effective June 1, 2014

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION
FOR
HEALTH EOS PLUS PLAN
(W262-13)

DISCLAIMER OF CLAIMS ADMINISTRATOR

We have prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your plan's fiduciaries and/or trustees, you are fully responsible for all legal issues that concern the plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this plan.

BY THIS AGREEMENT, Walworth County Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Walworth County on or as of the day and year first below written.

By _____
Walworth County

Date 9/16/14

Witness _____

Date 9/16/14

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
WALWORTH COUNTY
HEALTH PLAN
(W262-13)

This booklet is the Plan Document and Summary Plan Description. Its purpose is to summarize the provisions of the Plan that provide and/or affect payment or reimbursement. The Summary Plan Description supersedes any and all Summary Plan Descriptions issued to the *Plan Participant* by Walworth County.

The Plan is funded by Walworth County and *Plan Participant* contributions, if required. The benefits and principal provisions of the group plan are described in this booklet. They are effective only if the *Plan Participant (s)* are eligible for the coverage, become covered, and remain covered in accordance with the provisions of the group plan.

The purpose of providing a comprehensive medical plan is to protect the *Plan Participants* from serious financial loss resulting from necessary medical care. However, we must recognize and deal with escalating costs. Being fully informed about the specific provisions of the Plan will help both the *Plan Participant* and the *County* maintain reasonable rates in the future. We have prepared the following pages as a general guide for *Plan Participants* to become "good consumers" of health care. It will take a joint effort between *Eligible Providers*, *Plan Participants* and us, the *County*, to make our Plan work, both now and in future years.

All health benefits described herein are being provided and maintained for the *Plan Participants* and the covered dependents by Walworth County, hereinafter referred to as the "*County*." Auxiant will process all benefit payments.

- **Please refer to the address on the ID card to determine where to send claims.**

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WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

TO: ALL HEALTH *PLAN PARTICIPANT*S

FROM: WALWORTH COUNTY AND AUXIANT

SUBJECT: WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires Walworth County to notify you, as a participant or beneficiary of the Walworth County Health Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending *Physician* for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. *Surgery* and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Items 1. and 2. above will be payable under the *Inpatient Surgery* benefit, and item 3. will be payable under the prosthetic benefit. For further details on *Deductible* and *Coinsurance* for these benefits, please refer to your Summary Plan Description.

Please contact Walworth County or the *Claims Administrator*, Auxiant, at (800) 279-6772 for more information.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Walworth County (the "*County*" or the "Plan Sponsor") as of June 1, 2014 hereby sets forth the provisions of the Walworth County Health Plan (the "Plan"), which was originally adopted by the *County*, effective January 1, 2012.

Effective Date
The Plan Document is effective as of the date first set forth above, and each *Amendment* is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settler of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description and it amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Walworth County

By: _____

Name: _____

Date: _____ Title: _____

PLAN DESCRIPTION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible *Plan Participant*s, in accordance with the terms and conditions described herein. Plan benefits may be self funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from *Plan Participants* and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. *Plan Participants* in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible *Plan Participant*s, the economic effects arising from a Non-occupational *Injury* or *Sickness*. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for *Hospital* and medical benefits. The Plan Document is maintained by the Walworth County and may be inspected at any time during normal working hours by any *Plan Participant*.

PLAN DESCRIPTION INFORMATION

Name of Plan:	**Walworth County Health Plan**
Plan Sponsor:	**Walworth County** **100 West Walworth Street** **P.O. Box 1001** **Elkhorn, WI 53121** **Phone: (262) 741-7950** **Fax: (262) 741-7963**
***Plan Administrator*:** **(Named *Fiduciary*)**	**Walworth County Human Resources/Benefits** **100 West Walworth Street** **P.O. Box 1001** **Elkhorn, WI 53121** **Phone: (262) 741-7950** **Fax: (262) 741-7963**
Plan Sponsor ID No. (EIN):	**39-6005752**
Source of Funding:	**Self-Funded**
***Plan Year*:**	**January 1 through December 31**
Plan Number:	**W262-13**
DOL Plan Reporting Number:	**501**
Plan Type:	**Medical** ***Prescription Drug***
Claims Administrator:	**Auxiant** **2450 Rimrock Road** **Suite 301** **Madison, WI 53713** **Phone: (800) 279-6772** **Fax: (608) 273-4554** **Email/Website: www.auxiant.com**
Participating *Employer(s)*:	**Walworth County**
Agent for Service of the Legal Process:	**Walworth County** **County Clerk** **P.O. Box 1001** **Elkhorn, WI 53121** **Phone: (262) 741-4241** **Fax: (262) 741-4287**

The Plan shall take effect for this *Employer* on the Effective Date, unless a different date is set forth above opposite this *Employer's* name.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

Not a Contract
This Plan Document and any *Amendments* constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the *County* and any *Plan Participant* or to be consideration for, or an inducement or condition of, the employment of any *Plan Participant*. Nothing in this Plan Document shall be deemed to give any *Plan Participant* the right to be retained in the service of the *County* or to interfere with the right of the *County* to discharge any *Plan Participant* at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the *County* with the bargaining representatives of any *Plan Participant*s.

Mental Health Parity
Pursuant to the *Mental Health Parity and Addiction Equity Act of 2008*, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the *Plan Administrator*.

Applicable Law
This is a self-funded benefit plan coming within the purview of the laws of the State of Wisconsin. The Plan is funded with *Plan Participant* and/or *Employer* contributions.

Discretionary Authority
The *Plan Administrator* shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a *Plan Participant*s' rights; and to determine all questions of fact and law arising under the Plan.

Named *Fiduciary* and *Plan Administrator*
The Named *Fiduciary* and *Plan Administrator* is Walworth County Human Resources/Benefits, who will have the authority to control and manage the operation and administration of the Plan. The *Plan Administrator* (or similar decision-making body) has the sole authority and discretion to: establish the terms of the Plan; determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, the terms and provisions of the Plan, and the meaning of any alleged vague or ambiguous term or provision; determine payment of benefits or claims under the Plan; and to decide any and all other matters arising under the Plan. The *Plan Administrator* has the final and discretionary authority to determine the *Usual, Reasonable & Customary* amount.

Contributions to the Plan
The amount of contributions to the Plan is to be made on the following basis:

Contributions to the Plan are made by the *Employer*, which include *Plan Participant* contributions. The

Employer reserves the right to increase or decrease *Plan Participant* contribution requirements from time to time. Notwithstanding any other provision of the Plan, the *Employer's* obligation to pay claims under the terms of the Plan will be limited to its obligation to make contributions to the Plan. Payment of claims in accordance with these procedures will discharge completely the *Employer's* obligation with respect to such payments. In the event that the *Employer* terminates the Plan, the *Employer* and *Plan Participants* will have no further obligation to make additional contributions to the Plan as of the effective date of termination of the Plan.

Plan Modification and *Amendments*
Subject to any negotiated agreements, the *Employer* may modify, amend, or discontinue the Plan without the consent of or notice to *Plan Participants.* Any changes made shall be binding on each *Plan Participant*. This right to make *Amendments* shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan
The *Employer* reserves the right at any time to terminate the Plan. The termination must be in writing. All previous contributions by the *Employer* will be used to pay benefits under the provisions of this Plan for claims arising before termination, or will be used to provide similar health benefits to *Plan Participants*, until all contributions are exhausted.

Claim Procedure
The *Employer* will provide adequate notice in writing to any *Plan Participants* whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the *Plan Participant*. Further, the *Employer* will afford a *Reasonable* opportunity to any *Plan Participant*, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the *Employer* for that purpose.

Protection against Creditors
Benefit payments under this Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind. Any attempt to sell, transfer, garnish, or otherwise attach benefit payments under the plan in violation of this restriction will be void. If the *Employer* discovers an attempt has been made to attach, garnish, or otherwise improperly assign or sell a benefit payment in violation of this section that would be due to a current or former *Plan Participant*, the *Employer* reserves the right to terminate the interest of that individual in the payment, and instead apply that payment to or for the benefit of the *Plan Participant*, dependents or spouse as the *Employer* may otherwise decide. The application of the benefit payment in this manner will completely discharge all liability for such benefit payment.

Indemnification
No director, officer, or *Plan Participant* of the *Employer* or of the *Claims Administrator* will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act or omission done in good faith in the administration or management of the Plan, and will be indemnified and held harmless by the *Employer* from and against any such personal liability, including all expenses reasonably *Incurred* in his defense if the *Employer* fails to provide such defense. The *Employer* and the Plan may individually obtain *Fiduciary* liability coverage consistent with applicable law.

National Correct Coding Initiative
Where not otherwise specified, this Plan follows National Correct Coding Initiative (NCCI) for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The *Plan Administrator* has full discretionary authority to select guidelines and/or vendors to assist in determinations.

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

Certificates of *Creditable Coverage*
Should any *Plan Participant* or former *Plan Participant* need a copy of a Certificate of *Creditable Coverage*, they will be provided free of charge upon request. Please contact the Plan Sponsor at

Walworth County Human Resources/Benefits
100 West Walworth Street
P.O. Box 1001
Elkhorn, WI 53121
Phone: (262) 741-7950
Fax: (262) 741-7963

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the *Plan*, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

The Schedule of Benefits table beginning on page 14 is just a summary of your benefits. Please review specific plan provisions within the document to ensure you understand the complete benefit(s).

Note: The following section is an overview of the Plan.

BENEFIT OVERVIEW

FOR

WALWORTH COUNTY

Eligibility Provisions

The Plan Participant should notify the Employer of eligibility changes (i.e., Total Disability, retirement, Medicare eligibility, change in Dependent status – birth, marriage, divorce, etc.) no later than deadline as established in this document.

EFFECTIVE DATE OF PLAN	January 1, 2014 and restated June 1, 2014.
ELIGIBLE CLASS	All individuals who are employed by Walworth County in a qualifying position, a County Board Supervisor, elected officers, or a qualifying retiree of Walworth County, subject to County Personnel Policy and/or any applicable collective bargaining agreement or County Ordinance.
***PLAN PARTICIPANT* EFFECTIVE DATE**	An individual will be eligible on the first day of the month following 30 days of continuous active employment. Non-Eligible *Employees* of the *Employer*, who become eligible *Regular Basis Employees*, are subject to the waiting period.
CONTRIBUTION	The Plan may be evaluated from time to time to determine the amount of *Plan Participant* contribution (if any) required.

***Hospital* Pre-Admission Certification**
Continued Stay Review

MANAGED CARE

The Plan requires that all non-*Emergency* Inpatient hospitalizations (*Hospital*, *Skilled Nursing Facility*, *Birthing Center*, and other facilities) and certain *Outpatient* surgeries be pre-certified by the *Review Organization* 24 hours prior to the hospitalization; all *Emergency* Inpatient hospitalizations must be reported within the next business day after admission. If an in-*Hospital* stay is not pre-certified by the *Review Organization*, benefits related to the hospitalization will be reduced by $200 for admissions only. (The penalty does not apply to the Annual *Deductible* or Out-of-Pocket Maximum.)

PLAN LIMITATIONS AND MAXIMUMS OVERVIEW

Negotiated Fee or *Usual, Reasonable and Customary*	All charges are subject to either the *Negotiated Fee* (if the Provider is a Network Provider) or the *Usual, Reasonable and Customary* (U&C) fee for the area in which the service or supply is received, unless otherwise noted.
Hospital Room and Board Limitation	*Semi-private* rate
Intensive Care Unit Limitation	*ICU* rate
Skilled Nursing Facility Room and Board Limitation	*Semi-private* rate
Maximum *Plan Year* Benefit for All Medical Expenses (Includes all other maximums)	Unlimited
Maximum Benefit for *TMJ* (Temporomandibular Joint Disorder)	$1,250 per *Calendar Year* for non-surgical treatment
Maximum Benefit for *Skilled Nursing Facility*	90 days per 12 months
Maximum Benefit for Home Health Care	40 visits per *Calendar Year*
Maximum Benefit for Acupuncture in lieu of general anesthesia combined with Chiropractic Care	$600 per *Calendar Year*
Maximum Benefit for Chiropractic Care combined with Acupuncture above	$600 per *Calendar Year*
Maximum Benefit for *Occupational, Physical,* and Speech Therapy combined	60 visits per *Calendar Year*

SCHEDULE OF MEDICAL BENEFITS
PPO NETWORK PLAN

The Plan utilizes a Preferred Provider Organization (PPO) that, through negotiation, offers discounts for using the preferred providers for medical care. If the Plan Participant utilizes the PPO providers for eligible services, the Plan Participant will receive the in-network benefit listed below. To obtain a list of the preferred providers, please reference the information provided on the ID card.

• ALL services under the PPO Plan must be provided by participating providers to be covered at the Network benefit level. Services received elsewhere will be paid at the Non-Network level. If any of the following circumstances apply, benefits will be payable at the Network level, however, Usual, Reasonable and Customary will not apply to those Non-Network fees:

- *Charges for pathologist, independent lab, Emergency room Physicians, anesthesiologist, or radiologist when services are provided at a Network facility or referred by a Network provider, even when the provider is a Non-Network Provider.*
- *If Emergency Services are received from a Non-Network Hospital, qualified treatment facility, or qualified practitioner, all covered expenses are payable under the Network Provider level of benefits.*

Claims Audit
In addition to the Plan's Medical Record Review process, the *Plan Administrator* may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the *Plan Administrator* has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not *Usual, Reasonable and Customary* and/or *Medically Necessary* and *Reasonable*, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the *Plan Administrator* or its agent to identify the charges deemed in excess of the *Usual, Reasonable and Customary* and *Reasonable* amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the *Plan Administrator* has the discretionary authority to reduce any charge to a *Usual, Reasonable and Customary* and *Reasonable* charge, in accord with the terms of this Plan Document.

Medical Record Review
The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the *Plan Administrator* may determine the ***Maximum Allowable Charge*** according to the Medical Record Review and audit results.

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
MAXIMUM *PLAN YEAR* BENEFIT AMOUNT	Unlimited	
Note: The Network & Non-Network *Deductible* and Out-of-Pocket maximums DO NOT cross-satisfy one another. Any other benefit maximums cross-satisfy one another.		
DEDUCTIBLE*,** **PER *CALENDAR YEAR		
Per *Plan Participant*	$1,500	$3,000
Per *Family Unit*	$3,000	$6,000
Members of family plans must satisfy the entire family deductible before any one member has benefits paid.		
The *Deductible* does not apply to: • Pre-admission Testing; • Health Risk Management; and • Network Routine services.		
MAXIMUM OUT-OF-POCKET AMOUNT, **PER *CALENDAR YEAR***		
The Out-of-Pocket is the *Maximum Amount* paid by the *Plan Participant* in the *Calendar Year*. Charges noted below as not applying to the Out-of-Pocket do not calculate toward the Out-of-Pocket amount.		
For *Deductible*/*Coinsurance*		
Per *Plan Participant*	$2,000	$4,500
Per *Family Unit*	$4,000	$9,000
For Prescription *Co-payments* (Effective January 1, 2015)		
Per *Plan Participant*	$4,450	Unlimited
Per *Family Unit*	$8,900	Unlimited
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the *Calendar Year* unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • Ineligible charges; and • Amounts over the *Usual, Reasonable & Customary*, • Prescription Drug copays (after the deductible has been met).		
COVERED SERVICES PROFESSIONAL FEES - See separate categories for Infertility, Preventive, *Psychiatric Care*, Organ Transplants, Rehabilitation, Jaw Joint/*TMJ*, and *Pregnancy*		
Acupuncture In lieu of general anesthesia when pre-authorized by this Plan. $600 per *Calendar Year* maximum combined with Chiropractic/*Spinal Manipulation*.	90% after *Deductible*	70% after *Deductible*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
Allergy Injections/Serum Office	90% after *Deductible*	70% after *Deductible*
Allergy Injections/Serum *Inpatient* /*Outpatient*	90% after *Deductible*	70% after *Deductible*
Allergy Testing Office	90% after *Deductible*	70% after *Deductible*
Allergy Testing *Inpatient* and *Outpatient*	90% after *Deductible*	70% after *Deductible*
Ambulance Service	90% after *Deductible*	Paid at Network level
Chemotherapy/Radiation Therapy *Inpatient*/Office and *Outpatient* Professional Pre-authorization is required for prescribed treatment.	90% after *Deductible*	70% after *Deductible*
Chemotherapy/Radiation Therapy *Outpatient* Facility Pre-authorization is required for prescribed treatment.	90% after *Deductible*	70% after *Deductible*
Chiropractic/*Spinal Manipulation* $600 *Calendar Year* maximum combined with Acupuncture Maximum includes chiropractic lab, x-rays, supplies and evaluation and management fees.	90% after *Deductible*	70% after *Deductible*
Custom Molded Foot *Orthotics* $150 *Calendar Year* maximum combined with Specified Podiatry Services maximum	90% after *Deductible*	70% after *Deductible*
Diabetic Supplies (see the *Prescription Drug* section for diabetic medications covered under the *Prescription Drug* Program)	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab/X-ray *Emergency* Room	90% after *Deductible*	Paid at Network level
Diagnostic Lab by Independent Lab	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab/X-ray *Inpatient* and *Outpatient*	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab/X-ray Office	90% after *Deductible*	70% after *Deductible*
Diagnostic X-ray Office Radiologist Fees	90% after *Deductible*	70% after *Deductible*
Durable Medical Equipment	90% after *Deductible*	70% after *Deductible*
Health Risk Management	100% *Deductible* waived	100% *Deductible* waived
Hearing Aids/Cochlear Implants (Hospital Charges) Covered for dependent children to age 18 at one aid per ear per three (3) years.	90% after *Deductible*	70% after *Deductible*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
Hearing Aids/Cochlear Implants (Other) Includes the device, surgery, and follow up sessions. Covered for dependent children to age 18 at one aid per ear per three (3) years.	Paid at Non-Network level	70% after *Deductible*
Home Health Care 40 visits *Calendar Year* maximum Includes nutrition counseling when *Medically Necessary*.	90% after *Deductible*	70% after *Deductible*
***Hospice* Care** Includes nutritional counseling.	90% after *Deductible*	70% after *Deductible*
Injections office	90% after *Deductible*	70% after *Deductible*
Injections *Inpatient* /*Outpatient*/Home	90% after *Deductible*	70% after *Deductible*
Morbid Obesity Only if meets definition. Surgical treatment limited to one *surgical procedure* per *Lifetime*.	Paid same as any other *Illness*	Paid same as any other *Illness*
Orthotics Custom molded foot *Orthotics* are covered as shown in the Schedule of Benefits.	90% after *Deductible*	70% after *Deductible*
Other Covered Services	90% after *Deductible*	70% after *Deductible*
***Physician Emergency* Room Visits**	90% after *Deductible*	Paid at Network level
***Physician Inpatient* Visits**	90% after *Deductible*	70% after *Deductible*
***Physician* Office Visits**	90% after *Deductible*	70% after *Deductible*
***Physician Outpatient* Visits**	90% after *Deductible*	70% after *Deductible*
Specified Podiatry Services $150 *Calendar Year* maximum combined with Custom Molded Foot *Orthotics*	90% after *Deductible*	70% after *Deductible*
Private Duty Nursing	90% after *Deductible*	70% after *Deductible*
Prosthetics	90% after *Deductible*	70% after *Deductible*
Second Surgical Opinion	90% after *Deductible*	70% after *Deductible*
Third Surgical Opinion	90% after *Deductible*	70% after *Deductible*
Supplies Non Durable Office	90% after *Deductible*	70% after *Deductible*
Supplies Non Durable Other	90% after *Deductible*	70% after *Deductible*
Surgery below includes professional fees for anesthesia and assistant surgeon		
Surgery *Inpatient*	90% after *Deductible*	70% after *Deductible*
Surgery Office	90% after *Deductible*	70% after *Deductible*
Surgery *Outpatient*	90% after *Deductible*	70% after *Deductible*
Urgent Care Clinic (Free-standing facility)	90% after *Deductible*	70% after *Deductible*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
COVERED SERVICES *HOSPITAL* FEES - See separate categories for Infertility, Preventive, *Psychiatric Care*, Organ Transplants, Rehabilitation, Jaw Joint/*TMJ*, and *Pregnancy*		
***Inpatient* Room and Board** Limited to the semiprivate room rate	90% after *Deductible*	70% after *Deductible*
Intensive Care Unit Limited to the *Hospital*'s *ICU* Charge	90% after *Deductible*	70% after *Deductible*
***Inpatient* Miscellaneous** Charges	90% after *Deductible*	70% after *Deductible*
***Outpatient Emergency* Room**	90% after *Deductible*	Paid at Network level
***Outpatient* Diagnostic**	90% after *Deductible*	70% after *Deductible*
Outpatient Surgery	90% after *Deductible*	70% after *Deductible*
***Outpatient* Pre-Admission Testing** Within seven (7) days of admittance.	100% *Deductible* waived	Paid at Network level
Skilled Nursing Facility 90 days per 12 months maximum	90% after *Deductible*	70% after *Deductible*
Urgent Care Room (*Hospital* billed)	90% after *Deductible*	70% after *Deductible*
***Outpatient* Clinic Fee** (*Hospital* billed)	90% after *Deductible*	70% after *Deductible*
COVERED SERVICES FOR BOTH PROFESSIONAL AND *HOSPITAL* FEES FOR THE FOLLOWING DIAGNOSES:		
Infertility Benefits (see the *Prescription Drug* section for infertility medications covered under the *Prescription Drug* Program)	Paid same as any other *Illness*	Paid same as any other *Illness*
Includes: care, supplies and services for the diagnosis of infertility. The treatment of infertility is not covered.		
Jaw Joint/*TMJ* $1,250 *Calendar Year* maximum for non-surgical treatment. Pre-authorization is required.	Paid same as any other *Illness*	Paid same as any other *Illness*
Organ Transplants at designated Center of Excellence Lodging and transportation limited to $5,000 per transplant	100% *Deductible* waived	100% *Deductible* waived
Organ Transplants not at designated Center of Excellence	Paid same as any other *Illness*	Paid same as any other *Illness*
Pregnancy	Paid same as any other *Illness*	Paid same as any other *Illness*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
Preventive Care Routine *Well-Care* The following are considered routine: Mammograms: Ages 0-39 – one (1) baseline exam only if family history in immediate family Ages 40+ - one (1) per *Calendar Year* OB/GYN exam – one (1) per *Calendar Year* Prostate exam – one (1) per *Calendar Year* Routine surgeries (colonoscopy) – one (1) baseline exam at age 50 and then one (1) exam per five (5) years EKG – one (1) baseline for age 18+. Other EKGs covered when *Medically Necessary*. Well Child Care exams through age six (6) – no visit limit Routine exams ages seven (7) and older – one (1) per *Calendar Year* Routine vision exam to age (5) Mental Health screening – one (1) per *Calendar Year* Smoking cessation – office visits/counseling fees Fecal Occult Blood Test – one (1) per *Calendar Year* for ages 50+ Pap Smear Immunizations – limited to those approved by the Centers for Disease Control and Prevention Lab/x-rays Well Child blood lead tests to age six (6)	100% *Deductible* waived	70% after *Deductible*
Preventive Care Routine vision exam ages five (5) and older – $50 per *Calendar Year* maximum for age 19 and older (combined In-Network and Non-Network). No dollar maximum for under age 19.	90% after *Deductible*	70% after *Deductible*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
Contraceptives The administration and supply for injectables, diaphragms, implants, IUD's, and office visits and laboratory work associated with contraceptives and sterilization procedures for females.	100% *Deductible* waived	70% after *Deductible*
Psychiatric Care - Mental Disorders* and *Substance Abuse		
Inpatient Facility and Residential Treatment – This includes any services while done during an *Inpatient* or residential stay	90% after *Deductible*	70% after *Deductible*
Emergency Room	90% after *Deductible*	Paid at Network level
Urgent Care Room (*Hospital* billed)	90% after *Deductible*	70% after *Deductible*
Outpatient Facility and other *Transitional Treatment* - This includes any services billed as *Outpatient* or in a partial stay facility	90% after *Deductible*	70% after *Deductible*
Outpatient Professional Fees	90% after *Deductible*	70% after *Deductible*
Office Evaluation and Management fees	90% after *Deductible*	70% after *Deductible*
Office Counseling fees	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab & X-ray-Office	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab & X-ray-other than office	90% after *Deductible*	70% after *Deductible*
Urgent Care Clinic (Free-standing facility)	90% after *Deductible*	70% after *Deductible*
REHABILITATION THERAPY FOR BOTH PROFESSIONAL AND *HOSPITAL* FEES (*Inpatient Hospital* fees are included in *Inpatient* miscellaneous *Hospital* fees above)		
Cardiac Rehabilitation Professional Fees	90% after *Deductible*	70% after *Deductible*
Cardiac Rehabilitation *Hospital* Fees	90% after *Deductible*	70% after *Deductible*
Hemodialysis Treatment In Clinic of Dialysis Center For at home treatment (peritoneal dialysis) $10,000 maximum per month begins the first month of treatment. For office/outpatient treatment $10,000 maximum per month begins the fourth month of treatment.	90% after *Deductible*	70% after *Deductible*

	NETWORK PROVIDERS **% of Network *Negotiated Fee***	**NON-NETWORK PROVIDERS** **% of *Usual, Reasonable & Customary***
Hemodialysis Treatment *Hospital* Fees For at home treatment (peritoneal dialysis) $10,000 maximum per month begins the first month of treatment. For office/outpatient treatment $10,000 maximum per month begins the fourth month of treatment.	90% after *Deductible*	70% after *Deductible*
Home Infusion Therapy Professional Fees	90% after *Deductible*	70% after *Deductible*
Home Infusion Therapy Home	90% after *Deductible*	70% after *Deductible*
IV Therapy Professional Fees	90% after *Deductible*	70% after *Deductible*
IV Therapy *Hospital* Fees	90% after *Deductible*	70% after *Deductible*
Occupational Therapy* **Office/*Outpatient*** 60 visits *Calendar Year* maximum combined with *Physical Therapy* and Speech Therapy	90% after *Deductible*	70% after *Deductible*
Physical Therapy* **Office/*Outpatient*** 60 visits *Calendar Year* maximum combined with *Occupational Therapy* and Speech Therapy	90% after *Deductible*	70% after *Deductible*
Speech Therapy* Office/*Outpatient* 60 visits *Calendar Year* maximum combined with *Physical Therapy* and *Occupational Therapy*	90% after *Deductible*	70% after *Deductible*
* Additional visits can be allowed if *Medically Necessary* or effective and pre-authorized with *Review Organization*.		

PRESCRIPTION DRUG BENEFIT

Retail Pharmacy Option
Limited to a 30-day supply

Generic drugs

Co-payment	Network Deductible then $10 co-pay

Formulary brand name drugs

Co-payment	Network Deductible then $25 co-pay

Non-*Formulary* Brand Name drugs

Co-payment	Network Deductible then the lesser of $50 or 25%

Aspirin, Generic only and OTC requires a prescription (Men age 45 to 79 and Women age 55 to 79),
Folic acid, Generic only and OTC requires a prescription (Women to age 55),
Iron supplements, OTC requires a prescription (*Child*ren age 6 to 12 months),
Oral fluoride pills (*Child*ren 6 months to 6 years), and
Erythromycin ophthalmic ointment (*Newborn* 0 to 3 months)
Immunizations for Influenza, Pneumonia, and Shingles ((Zostavax) age 60 and older, limit 1 per lifetime) at select pharmacy retailers- contact company identified on your Drug Card for additional information.

Co-payment	$0

Mail Order *Prescription Drug* Option
Available for maintenance drugs. Maintenance drugs are those taken for long periods of time, such as drugs prescribed for heart disease, high blood pressure, asthma, etc.
Limited to a 90-day supply

Generic drugs

Co-payment	Network Deductible then $25 co-pay

Formulary brand name drugs

Co-payment	Network Deductible then $62.50 co-pay

Non-*Formulary* brand name drugs

Co-payment	Network Deductible then the lesser of $150 or 25%

Aspirin, Generic only and OTC requires a prescription (Men age 45 to 79 and Women age 55 to 79),
Folic acid, Generic only and OTC requires a prescription (Women to age 55),
Iron supplements, OTC requires a prescription (*Child*ren age 6 to 12 months),
Oral fluoride pills (*Child*ren 6 months to 6 years), and
Erythromycin ophthalmic ointment (*Newborn* 0 to 3 months)

Co-payment	$0

Specialty Medications Option
Applies to both Retail and Mail Order Prescription Drugs

Generic drugs

Co-payment	Network Deductible then $10 per 30 days

Formulary brand name drugs

Co-payment	Network Deductible then $25 per 30 days

Non-*Formulary* brand name drugs

Co-payment	Network Deductible then the lesser of $50 or 25%

* Generic Contraceptive Prescription drugs are a $0 co-payment with first dollar coverage, as required under PPACA.

* Certain Prescriptions written for Preventive care may be covered at the generic level if no generic option is available, as required under PPACA. For a complete list of covered Prescription drugs and for

information regarding drugs covered for Preventive care, please refer to the website or booklet information provided by the company identified on your Drug Card.

** Tobacco cessation medications (including both prescription and over-the-counter medications (eg, Chantix, bupropion, nicotine replacement products)) for a 90-day treatment regimen without prior authorization. Two tobacco cessation attempts are allowed per year. [Coverage does not apply to brands where an equivalent generic is available.]

Step Therapy

In addition to promoting generic and *Formulary* brand use, the Plan includes a Step Therapy program administered by The *Prescription Drug* Plan Supervisor, unless otherwise provided by collective bargaining agreement. This program contains specific drugs that may have high-cost brand, low-cost generic drugs and over-the-counter (OTC) options only as specified.

Points of Step Therapy:

- Means that you may be required to use equally safe and effective generic or OTC drugs to treat your medical condition before authorization is granted for a more costly brand or non-preferred generic drug.
- All failure of previous steps in the program must be either in the patient history in the *Prescription Drug* Plan Supervisor claims database, or notes from the patient's medical chart must be FAXED to the *Prescription Drug* Plan Supervisor showing failure.
- All Prior Authorization forms are available by contacting the *Prescription Drug* Plan Supervisor.
- Failure on the part of the *Physician* to fill out the Prior Authorization form completely or to not attach chart notes showing past failures may result in a delay in the *Plan Participant*'s therapy.
- There will be savings for both you and your *Employer* if you follow Step Therapy recommendations.

HSA

The Health Savings Account (HSA), which is part of this Plan, was established in conjunction with the Employer to create an incentive for employees to participate in the cost containment effort as it applies to health care spending. The Health Savings Account funding may be made by the Employer or Employees and is portable.

The goal is to reduce health care spending by giving control of medical care spending to the employee.

The Calendar Year Deductible and Out-of-Pocket amounts will be adjusted on an annual basis according to standards set by the IRS, the Department of Labor, or any other regulatory agency.

See the Employer for more information regarding the Health Savings Account.

ELIGIBILITY

ELIGIBILITY: Individuals who belong to an **Eligible Class** are eligible for coverage under this Plan following the waiting period.

ELIGIBLE CLASS:

- All individuals who are employed by Walworth County in a qualifying position, a County Board Supervisor, elected officers, or a qualifying retiree of Walworth County, subject to *County* Personnel Policy and/or any applicable collective bargaining agreement or *County* Ordinance.

WAITING PERIOD: An *Employee* is eligible on the first day of the month following a waiting period of 30 days of continuous active employment with the *Employer*.

A "waiting period" is the time between the first day of active employment and the first day of coverage under the plan.

A group health plan may not base rules for eligibility for coverage upon an individual being "*Actively at Work*," if a health factor is present. If a *Plan Participant* is absent from work due to a health factor, for purposes of plan eligibility, the individual is to be considered "*Actively at Work*."

Non-Eligible *Employees* who become eligible *Employees* will NOT be given credit towards satisfaction of the waiting period while employed on a non-eligible basis.

EFFECTIVE DATE

Coverage under the Plan shall become effective on the date of the individual's eligibility provided he/she has made written application for such coverage on or before such date. The individual must apply for coverage within 31 days of eligibility for coverage to be effective on the date of eligibility. Please see the Enrollment section for all requirements of Timely, *Special* and *Late Enrollees*.

DEPENDENT ELIGIBILITY

The following persons are eligible for *Dependent Coverage* under this plan:

1. LAWFUL SPOUSE – A *Plan Participant's* lawful spouse in the state of residence, living in the same country, if not legally separated or divorced. The *Plan Administrator* may require documentation proving a legal marital relationship. A retiree's lawful spouse who is eligible for *Medicare* is an eligible dependent.

   Not considered eligible for spousal coverage:
   a) Common Law Spouses; and
   b) Same sex marriages/domestic partnerships

   If a divorce is pending, a Spouse cannot be dropped from coverage until the divorce is finalized. A finalized divorce decree must be submitted in order to drop Spouse's coverage from this Plan.

2. *CHILD*REN TO AGE 26 – A *Plan Participant's Child* up to age 26 is eligible for coverage through this plan regardless of marital status, employment status, or existence of other coverage. However, if the *Child* has coverage through their own *Employer* or through their own spouse, then this coverage will pay all benefits as secondary to that coverage as outlined in the

Coordination of Benefits section in this plan document. When the *Child* reaches limiting age, coverage will end on the last day of the *Child*'s birthday month.

MILITARY SERVICE EXTENSION (WISCONSIN STATE MANDATE): A *Child* enrolled in this plan under this eligibility section who is under age 27 and who is called to federal active military service duty in the National Guard or a reserve component of the U.S. armed forces while the *Child* was attending, on a full time basis, an institution of higher education, and such full time service call interrupts their eligibility for coverage under this plan past the date the *Child* reaches age 26, will be eligible for coverage under this Plan for up to twelve months of coverage if over the limiting age, upon release/return from active service duty provided the *Child* returns to school as a full-time student within 12 months of fulfilling the active duty obligation.

3. DEVELOPMENTALLY DISABLED OR PHYSICALLY HANDICAPPED *CHILD*REN – A *Plan Participant's* unmarried Dependent *Child* who is incapable of self-sustaining employment by reason of Developmental Disability or physical handicap, primarily dependent upon the *Plan Participant* for support and maintenance and covered under this Plan when the *Child* reaches the limiting age. Proof of physical or mental handicap must be submitted to the *Plan Administrator* within 31 days of the covered Dependent reaching the limiting age. Thereafter, proof may be required annually.

4. *CHILD*REN ENTITLED TO COVERAGE – as the result of one of the following:
    a) Qualified Medical Child Support Order (QMCSO);
    b) A National Medical Support Order;
    c) Divorce Decree; or
    d) Court Order.

The term "*Child*" or "*Child*ren" as referenced in the above sections includes:
a) An eligible *Plan Participant's* natural *Child*;
b) An eligible *Plan Participant's* adopted *Child* (from the date of placement);
c) An eligible *Plan Participant's* stepchild;
d) An eligible *Plan Participant's* grandchild until the *Dependent Child*'s parent is age 18;
e) Any other *Child* for whom the eligible *Plan Participant* has legal guardianship or for a *Child* for whom the eligible *Plan Participant* had noted legal guardianship on the *Child*'s 18th birthday (proof is required).

An "adopted *Child* (from the date of placement)" refers to a *Child* whom the eligible *Plan Participant* has adopted or intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 on the date of such placement for adoption. The term placement means the assumption and retention by such eligible *Plan Participant* of a legal obligation for total or partial support of the *Child* in anticipation of adoption of the *Child*. The *Child* must be available for adoption and the legal process must have commenced.

At any time, the Plan may require proof that a Spouse or a *Child* qualifies or continues to qualify as a Dependent as defined by the Plan.

In any event, no person may be simultaneously covered as both an eligible *Plan Participant* and a dependent. If both parents are eligible for coverage, only one may enroll for *Dependent Coverage*. Certain exceptions may apply to this rule under collective bargaining agreements or *county* ordinances. See the Human Resources/Benefits for more information.

Excluded Dependents include: other individuals living in the covered *Plan Participant's* home, but who are not eligible as defined; the legally separated or divorced former spouse of the eligible *Plan Participant*; any person who is on active duty in any military service of any country; or any individual who is eligible for coverage under this Plan as an eligible *Plan Participant*.

DEPENDENT EFFECTIVE DATE

A Dependent will be considered eligible for coverage on the date the eligible *Plan Participant* becomes eligible for *Dependent Coverage*, subject to all limitations and requirements of this Plan. Each eligible *Plan Participant* who makes such written request for *Dependent Coverage* on a form approved by the *Employer* shall, become covered for *Dependent Coverage* as follows:

1. If the eligible *Plan Participant* makes such written request on or before the date he or she becomes eligible for *Dependent Coverage*, or within the time frame listed in " eligible *Plan Participant* Eligibility" to enroll, the eligible *Plan Participant* shall become covered, with respect to those persons who are then his or her Dependents, on the date he or she becomes covered for *Plan Participant* coverage.

2. If the Dependent is a ***Newborn*** *Child* or newly **adopted** *Child*, then the Dependent is eligible for coverage from the date of the event (i.e., birth or date of placement). The newly-acquired Dependent must be enrolled and the *Claims Administrator* notified **within 60 days** of the date of the event. Benefits will not be paid until the Dependent is enrolled.

3. If a Dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new Dependent will be effective on the date of such court order, decree, or marriage if *Dependent Coverage* is in effect under the Plan at that time and proper enrollment is completed within 31 days of the event. If the eligible *Plan Participant* does not have *Dependent Coverage* in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new Dependent within the 31 day period immediately following the date of the court order, decree, or marriage, then *Dependent Coverage* will be retroactive to the date of the court order, decree, or marriage.

RETIREE ELIGIBILITY

Except as may otherwise be provided by collective bargaining agreements, the following *Employees* who began *county* service prior to December 1, 2005, shall, for a continuous and indefinite period, be eligible to remain in the group health care plan at retirement:

1. An *Employee* enrolled in the health care plan who retires on an immediate retirement annuity from the Wisconsin Retirement System (WRS). "Immediate" means the annuity application must be made within 60 days following the date of termination; or

2. An *Employee* enrolled in the health care plan that terminated *county* employment at age 50 or older and has a minimum of 20 years of *county* service at the time of termination, or

3. An *Employee* enrolled in the health care plan that applies for and receives a disability annuity from the WRS upon termination.

The following restrictions apply to retiree eligibility:

1. Changes in coverage. Any changes in coverage shall be subject to qualifying events as defined under the plan document, *COBRA* regulations, or *HIPAA* regulations.

2. Late enrollment not permitted. An otherwise eligible *Employee* who elects not to continue under the group health plan at retirement, except as provided in County Ordinance Section 15-339 (as outlined below), shall not be eligible to enroll at a later time.

3. Surviving spouse. A surviving spouse of a deceased retiree may continue with the group health care plan indefinitely.

4. Spouses both retirees. When each spouse who is a retiree of Walworth County is eligible for retiree health plan coverage, each retiree may elect single coverage in lieu of family coverage.

5. Transfer back to retiree insurance. When a retiree's spouse is employed by the *County* and is eligible to enroll in the health care plan, coverage may be maintained by the working spouse, and upon termination of coverage under the working spouse's health care benefit, coverage may be transferred back to the eligible retiree.

6. Premium payments. The retiree shall be responsible for full payment of the plan cost, except as otherwise provided under County Ordinance Section 15-339 or 15-362 (as outlined below or in the Walworth County Ordinance number as specified), or the terms of a collective bargaining agreement.

7. Except as may otherwise be provided by collective bargaining agreement, *Employees* beginning *county* service on or after December 1, 2005, shall not be eligible to remain in the group health care plan at retirement.

8. The payment terms and conditions for retirees for the purposes of conversion of sick leave to health plan credits are outlined in the Walworth County Ordinance Section 15-339.

TIMELY ENROLLMENT

The enrollment will be “timely” if the enrollment form is completed no later than 31-days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

LATE ENROLLMENT

Enrollment for coverage is required within 31 days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered *Plan Participant's* and/or Dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a *Late Enrollees*. Some late enrollments may be made under the following Special Enrollment provision; however, if the Special Enrollment provisions do not apply, the *Late Enrollees* will be effective the first of the month following the date the application was received in the Human Resouces/Benefits.

SPECIAL ENROLLMENT PERIODS

The *Enrollment Date* for anyone who enrolls under a Special Enrollment Period is the first date of coverage or for anyone who enrolls under a Special Enrollment Period, coverage is effective on the event date. Thus, the time between the date a *Special Enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage (proof is required). An individual or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The individual or Dependent was covered under a group health plan or had health insurance coverage or coverage through a state Medicaid or *Child*ren's Health Insurance Program (*CHIP*) program, at the time coverage under this Plan was previously offered to the individual.

2. If required by the *Plan Administrator*, the individual stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

3. The coverage of the individual or Dependent who had lost the coverage was under *COBRA* and the *COBRA* coverage was exhausted, or was not under *COBRA* and:

    a. the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or other cancellation by the Medicaid or *CHIP* program providing coverage); or
    b. *Employer* contributions towards the coverage were terminated; or
    c. the *Plan Participant* reaches or exceeds the *Plan Year Maximum Benefit* within the plan.

4. The individual or Dependent requests enrollment in this Plan no later than 31-days after the date of exhaustion of *COBRA* coverage or the termination of coverage or *Employer* contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

5. If the loss of coverage was through a Medicaid or *CHIP* program, the individual or Dependent requests enrollment in this Plan no later than 60-days after the date of exhaustion or cancellation by the Medicaid or *CHIP* program. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the individual or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Dependent beneficiaries if:

1. The individual is a *Plan Participant* under this Plan (or has met the Waiting Period applicable to becoming a *Plan Participant* under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

2. A person becomes a Dependent of the *Plan Participant* through marriage, birth, adoption or placement for adoption: or

3. The Dependent was previously covered through a Medicaid or *CHIP* program, and has lost eligibility for coverage through said program,

then the Dependent (and if not otherwise enrolled, the individual) may be enrolled under this Plan as a covered Dependent of the covered *Plan Participant*. In the case of the birth or adoption of a *Child*, the spouse of the covered *Plan Participant* may be enrolled as a Dependent of the covered *Plan Participant* if the spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31-days and begins on the date of the marriage, or a period of 60-days on the date of birth, adoption or placement for adoption. If the reason for enrollment is loss of coverage through a Medicaid or *CHIP* program, the Special Enrollment Period is a period of 60-days and begins on the date of loss of coverage through that plan.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

1. in the case of marriage, the date of marriage;

2. in the case of a Dependent's birth, as of the date of birth; or

3. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4. in the case of a loss of coverage through Medicaid or *CHIP*, the date of the loss of said coverage.

MANAGED CARE

Managed Care services are used by the Plan to keep health costs down. These services are utilized as a way to review and advise *Plan Participants* on how to best use their Plan Benefits.

Managed Care Services Phone Number

Please refer to the *Plan Participant's* ID card for the Managed Care Services phone number.

The patient, family member or attending *Physician* must call this number to receive certification of certain Managed Care Services. This call must be made at least 24 hours in advance of services being rendered or within the next business day after an *Emergency*.

Any reduced reimbursement due to failure to follow Managed Care procedures will not accrue toward the 100% maximum out-of-pocket payment.

Please remember that pre-certification approval does not verify eligibility for benefits nor guarantee benefit payments.

UTILIZATION REVIEW

As part of a program designed to keep down escalating costs, this Plan contains a Pre-certification program. The program requires that the *Plan Participant* follow certain steps before being admitted to the *Hospital* for Inpatient Treatment or before any listed service below.

The program consists of:

1. Pre-certification of the Medical Necessity for the following non-*Emergency Services* before Medical and/or Surgical services are provided:

   Hospitalizations – *Hospital*s, *Skilled Nursing Facility*, and other facilities.

   Outpatient Surgery – Colonoscopy, Bronchoscopy, Endoscopy, Hemorrhoidectomy, Laparoscopy, Nasal Surgery, Arthroscopy, Carpal Tunnel, Cardiac Catheterization, and D & C Non-Obstetric Surgery.

2. Retrospective review of the Medical Necessity of the listed services provided on an *Emergency* basis;

3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending *Physician*; and

4. Certification of services and planning for discharge from a *Medical Care Facility* or cessation of medical treatment.

The purpose of the program is to determine if a proposed *Hospital* stay is appropriate and if the treatment is appropriate for the indicated diagnosis. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *Physician* or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the indicated

diagnosis. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending *Physician* does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification

Before a *Plan Participant* enters a *Medical Care Facility* on a non-*Emergency* basis, the utilization review administrator will, in conjunction with the attending *Physician*, certify the care as appropriate for the indicated diagnosis. A non-*Emergency* stay in a *Medical Care Facility* is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the patient, family member or attending *Physician*. Contact the utilization review administrator at the telephone number on the ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered *Plan Participant*
- The name, Social Security number and address of the covered *Plan Participant*
- The name of the *Employer*
- The name and telephone number of the attending *Physician*
- The name of the *Medical Care Facility*, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an ***Emergency*** admission to the *Medical Care Facility*, the patient, patient's family member, *Medical Care Facility* or attending *Physician* must contact the utilization review administrator **within the next business day** after the admission.

The utilization review administrator will determine the number of days of *Medical Care Facility Confinement* authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the *Plan Participant* does not receive authorization as explained in this section, the benefit payment will be reduced by $200 for admissions only.

Concurrent review, discharge planning

Concurrent review of a course of treatment and discharge planning from a *Medical Care Facility* are parts of the utilization review program. The utilization review administrator will monitor the *Plan Participant's Medical Care Facility* stay or use of other medical services. They will also coordinate either, the scheduled release, an extension of the *Medical Care Facility* stay, or an extension or cessation of the use of other medical services with the attending *Physician*, *Medical Care Facilities* and *Plan Participant*.

If the attending *Physician* feels that it is *Medically Necessary* for a *Plan Participant* to receive additional services or to stay in the *Medical Care Facility* for a greater length of time than has been pre-certified, the attending *Physician* must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's *Plan Participants* and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an *Emergency* or of a life threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending *Physician* and who is affiliated in the appropriate specialty.

PRE-DETERMINATION OF MEDICAL BENEFITS

You or your qualified practitioner may submit a written request for a pre-determination of benefits. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. Medical Management will provide a written response advising if the services are a covered or non-covered expense under the Plan, what the applicable Plan benefits are and if the expected charges are within the maximum allowable fee. The pre-determination of benefits is not a guarantee of benefits. Services will be subject to all terms and provisions of the Plan applicable at the time treatment is provided.

If treatment is to commence more than 90 days after the date treatment is authorized, Medical Management will require you to submit another treatment plan.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate *Medically Necessary* care. The case manager consults with the patient, the family and the attending *Physician* in order to develop a plan of care for approval by the patient's attending *Physician* and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring *Hospital* or *Skilled Nursing Facility*;

-- determining alternative care options; and

-- assistance obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *Physician*, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the Plan to reimburse for *Medically Necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

HOSPITAL BILL REVIEW INCENTIVE

This Plan includes an incentive for a *Plan Participant* to complete a self-audit of his/her *Hospital* bill. If, upon review of the *Hospital* bill, a *Plan Participant* finds an error that will reduce the total bill, the Plan will pay the *Plan Participant* fifty (50) percent of the reduction in the bill, subject to a maximum reward of $100 per bill. To claim the reward, the *Plan Participant* must report the error to the *Claims Administrator*.

MEDICAL EXPENSE BENEFITS

Upon receipt of a claim, the Plan will pay the *Benefit Percentage* listed in the Schedule of Benefits for *Eligible Expenses Incurred* in each *Benefit Period*. The amount payable, in no event, shall exceed the Maximum *Plan Year* Benefit stated in the Schedule of Benefits.

The *Deductible*

The *Deductible* is the amount of *Covered Medical Expenses* which must be paid by the *Plan Participant* before Medical Expense Benefits are payable. The amount of the *Deductible* is shown in the Schedule of Benefits. Each Family member is subject to the *Deductible* up to the Family maximum as shown in the Schedule of Benefits.

Family *Deductible* Feature

If the Family *Deductible* limit, as shown in the Schedule of Benefits, is *Incurred* by covered Family members during the *Calendar Year*, no further *Deductible*s will be required on any members for the rest of the year.

Coinsurance

The term *coinsurance* means the shared financial responsibility for *covered expenses* between the *Participant* and the *Plan*.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the *deductible*, if applicable, is satisfied each *calendar year*.

Common Accident Provision

If two or more covered members of a Family sustain bodily Injuries in the same accident, only one applicable annual individual medical *Deductible* amount will be applied for all covered expenses due to that accident during that year.

Usual, Reasonable and Customary Charges

Subject to the *Plan Administrator*'s exercise of discretion, the Plan shall pay no more than the *Usual, Reasonable and Customary* Charge for Non-Network covered services and/or supplies. All charges must be billed in accordance with generally accepted industry standards.

Covered expenses which are identified by the *Plan Administrator*, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be *Usual, Reasonable and Customary*, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "*Usual*" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals

with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is *Incurred*.

The term "*Customary*" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "*Usual, Reasonable and Customary*" does not necessarily mean the actual charge made nor the specific service or supply furnished to a *Plan Participant* by a Provider of services or supplies, such as a *Physician*, therapist, nurse, *Hospital*, or pharmacist. The *Plan Administrator* will determine what the *Usual, Reasonable* and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is *Usual, Reasonable and Customary*. The *Plan Administrator* consults with the *Claims Administrator* and vendors for reference in this process.

Usual, Reasonable and Customary charges may, at the *Plan Administrator*'s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Out-of-Pocket Limit

Covered charges are payable at the percentage shown each *Calendar Year* until the Out-of-Pocket limit shown in the Schedule of Benefits is reached. Then, covered charges *Incurred* by a *Plan Participant* will be payable at 100% (except for the charges excluded) for the rest of the *Calendar Year*.

When a family reaches the family Out-of-Pocket limit, covered charges for that family will be payable at 100% (except for the charges excluded) for the rest of the *Calendar Year*.

Deductibles, *Co-insurance*, and maximum out-of-pocket for In/Out network are separate.

Office visit *Co-payments*, and any other applicable *Co-payments*, are not applied to the out-of-pocket limit.

Penalties for non-compliance with plan provisions, amounts that exceed *Usual, Reasonable and Customary* fee limits, and ineligible services are not applied to the out-of-pocket limit.

Timely Notice of Claim

The *Plan Participant* must give written notice of claim within 12 months after the date *you* received *covered services* if the PPO provider does not notify the *Plan*. *A* claim will not be reduced or denied if it was not reasonably possible to give such notice. In any event, liability of the *Plan* for *services* rendered to a *Participant* terminate one (1) year from the date *services* were incurred.

Allocation and Apportionment of Benefits

The *Employer* reserves the right to allocate the *Deductible* amount to any eligible charges and to apportion the benefits to the *Plan Participant* and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the *Plan Participant* and all assignees.

Alternative Treatment

In addition to the *Covered Medical Expenses* specified, the *Claims Administrator* (on behalf of and in conjunction with the *Plan Administrator*) may determine and pre-authorize other services to be covered hereunder which normally are excluded services or have limited coverage under this Plan. The attending *Physician* or Case Manager must submit an Alternative Treatment plan to the *Claims Administrator* which indicates the diagnosis and Medical Necessity of the proposed medical services to be provided to the *Plan Participant*.

Based on this information, the *Claims Administrator* and/or its Medical Consultant(s) will determine and approve the period of time for which such medical service(s) will be covered under this Plan. Further, the *Claims Administrator* will make such a determination based on each circumstance and stipulate that its approval does not obligate this Plan to provide coverage for the same or similar services for other *Plan Participants* nor be construed as a waiver of its rights to administer this Plan in accordance with its established provisions.

Medical Eligible Expenses

Medical Eligible Expenses are the following expenses that are *Incurred* while coverage is in force for the *Plan Participant*. If, however, any of the listed expenses are excluded from coverage because of a reason described in the General Limitations section, those expenses will not be considered Medical Eligible Expenses.

The Plan will make payment for *Medical Eligible Expenses* subject to the Benefit *Deductible, Co-payments,* and *Benefit Percentages* and *Maximum Amounts* shown in the Schedule of Benefits.

***Hospital* Expenses**

Hospital expenses are the charges made by a *Hospital* in its own behalf. Such charges include:

1. *Hospital* charges for daily *Semi-private*, ward, intensive care or coronary care *Room and Board* charges for each day of *Confinement*. The *Maximum Amount* payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the maximum allowable fee charged for a *Semi-private* room in the *Hospital* while a registered bed patient.
2. Necessary *Hospital* services other than *Room and Board* as furnished by the *Hospital*, including but not limited to, general nursing services.
3. Special care units, including burn care units, cardiac care units, delivery rooms, *Birthing Centers*, *Intensive Care Units*, isolation rooms, Rehabilitation facilities, *Ambulatory Surgical Centers*, operating rooms and recovery rooms.
4. *Outpatient Emergency* Medical Care.
5. *Outpatient* (including Ambulatory Surgery) charges.

Skilled Nursing/Extended Care Facility Expenses

Skilled Nursing/Extended Care Facility Expenses are payable up to the maximum in the Schedule of Benefits. With respect to charges made by a *Skilled Nursing Facility* for the following services and supplies furnished by the facility, only charges *Incurred* in connection with convalescence from an *Injury* or *Sickness* are eligible for benefits. The *Confinement* must commence within 24 hours of discharge from the *Hospital* or a related *Confinement* in a *Skilled Nursing Facility*. These expenses include:

1. *Room and Board* (if private room accommodations are used, the daily *Room and Board* charges

allowed will not exceed the facility's average *Semi-private* charges);
2. General nursing services;
3. Medical services customarily provided by the Skilled Nursing/Extended Care Facility with the exception of private duty or special nursing services and *Physician*'s fees; and
4. Drugs, biologicals, dressings and casts furnished for use during the *Convalescent Period,* but no other supplies.

Home Health Care Expenses

Home Health Care is subject to the limit stated in the Schedule of Benefits. A *Physician* (either the person's primary care *Physician* or the primary *Physician* in the *Hospital*) must order Home Health Care, which must be provided by a licensed *Home Health Care Agency*. A *Home Health Care Plan* must be approved in writing and reviewed at least every two (2) months by the attending *Physician.* A *Physician* must certify that:

1. The *Plan Participant* would have to be hospitalized or Inpatient at a *Skilled Nursing Facility* if Home Health Care Services were not available;
2. It would cause the person's immediate family (spouse, children, parents, grandparents, siblings and their spouses) undue hardship to provide the necessary care; and
3. A licensed *Medicare*-certified *Home Health Care Agency* will provide or coordinate the services.

Services must be provided according to a written *Home Health Care Plan*. Covered Home Health Care Services and Supplies include:

1. Evaluation of the need for a *Home Health Care Plan* and development of the plan by an *R.N.* or medical *Social Worker*;
2. Home care visits by a *Physician*;
3. Part-time or intermittent home health aide services that are supervised by a *Registered Nurse* or medical *Social Worker* and are *Medically Necessary* for patient's care;
4. Part-time or intermittent nursing care by or under the supervision of a *Registered Nurse*;
5. *Physical*, respiratory, *occupational* and speech therapy;
6. Medical equipment, supplies and medications prescribed by a qualified practitioner;
7. Lab services by or on behalf of a *Hospital*, as long as they would have been covered for an Inpatient *Confinement*; and
8. Nutritional counseling from or supervised by a registered dietician.

The plan covers a set number of visits per person in a *Calendar Year*, as stated in the Schedule of Medical Benefits. A Home Health Care visit is any visit of up to four (4) hours by a Home Health Care provider.

The plan does not pay Home Health Care benefits for:

1. Services or supplies not included in the *Home Health Care Plan*.
2. Services of a *Close Relative*.
3. *Custodial Care*.
4. Food, housing, homemaker services or meals delivered to the home.
5. Transportation to and from the patient's home.

***Hospice* Expenses**

Hospice care for a terminally ill person provided in the *Hospice* unit, an *Outpatient* facility or the patient's home. A *Physician* must order the care and is expected that the patient has no more than six

months to live. The plan may extend *Hospice* care benefits beyond six (6) months if the patient's *Physician* certifies that the patient is still terminally ill. Covered *Hospice* Services and Supplies are:

1. *Room and Board*.
2. Part-time nursing care provided or supervised by a *Registered Nurse*.
3. Part-time services of a home health aide.
4. *Physical Therapy* provided by a licensed therapist.
5. Medical supplies, drugs and medical appliances prescribed by a qualified provider.
6. *Physician*'s services, including consultation and case management.
7. Dietary counseling.
8. Services of a licensed *Social Worker* for counseling the patient.
9. Bereavement counseling for the patient's immediate family.
10. Respite Care.

Hospice care benefits do not include:

1. Private or special duty nursing, except as part of a *Home Health Care Plan*.
2. *Confinement* not required to manage pain or other acute chronic symptoms.
3. Services of volunteers.
4. Services of a *Social Worker* other than a licensed clinical *Social Worker*.
5. Homemaker or caretaker services including sitter or companion, housecleaning or household maintenance.
6. Financial or legal counseling, including estate planning or drafting a will.
7. Services of a licensed pastoral counselor if the patient or family member belongs to his or her congregation.
8. Funeral arrangements.

Organ/Tissue Transplant Expenses

The Plan provides benefits for human organ and tissue transplants when *Medically Necessary*, as pre-certified by the Plan. Transplants that are determined by the *Claims Administrator* as directed by the Plan Administrator to be *Experimental*, Investigational or for research purposes are not covered.

Transplants are subject to all provisions of the Plan applicable at the time the expense is *Incurred*, including but not limited to, the limitations and exclusions and the definitions found in this Plan and the following additional Plan provisions:

1. When both the recipient and the donor are covered by the Plan, each is entitled to the benefits of the Plan;
2. When only the recipient is covered by the Plan, the recipient is entitled to the benefits of the Plan. The donor's benefits are limited to only those eligible charges for services to donate the tissue, joint or human organ and not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage, medical Plan or any government program. Benefits provided to the donor are charged against the recipient's coverage under the Plan;
3. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient;

4. If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to the evaluation and procurement are covered for the recipient up to the benefit limitation of the Plan.

The following will not be eligible for coverage under this benefit:

1. Expenses associated with the purchase of any organ.
2. Charges in connection with mechanical organs or a transplant involving a mechanical organ, except charges in relation to mechanical organs which may be necessary on a temporary short-term basis until a suitable donor organ is available will be eligible under the Plan.
3. Services or supplies furnished in connection with the transportation of a living donor.
4. Expenses associated with a non-human organ transplant.
5. Expenses associated with travel to the transplant facility unless participating in the transplant network.

Transplant Network Coverage

The *County* will participate in a Transplant Network when it is determined, by the *County*, to be a financial benefit to the Plan. If both the Plan and the *Plan Participant* agree to utilize the Transplant Network and a designed Center of Excellence, direct non-medical expenses (transportation and lodging to a maximum of $5,000 per transplant) and the out-of-pocket expenses for the patient will be paid as covered expenses.

***Physician* Services**

The professional services of a *Physician* for surgical or medical services including home and office visits, *Inpatient* and *Outpatient Hospital* care and visits, and *Inpatient* consultations. The *Eligible Expenses* for covered surgical services will be the *Negotiated Fee* or the *Usual, Reasonable and Customary* charges, whichever is applicable.

Charges for **multiple surgical procedures and assistant surgeons** will be a covered expense subject to the following provisions:

- The *Claims Administrator* as directed by the *Plan Administrator* follows the multiple surgical procedures and Assistant Surgeons Procedures as outlined in the Current Procedural Terminology (CPT) book, which could reduce benefit payments.

Covered Expenses
In Or Out Of the *Hospital*

1. *Hospital* services and supplies for the treatment of traumatic bodily injuries resulting from an **accident**, providing that services commence within 48 hours of the accident.

2. Charges for **acupuncture** when pre-authorized by the Plan and for use in lieu of general anesthesia are covered. Acupuncture must be performed by a state licensed acupuncturist acting within scope of his or her license. Maximum for acupuncture is combined with chiropractic maximum as shown in the Schedule of Benefits.

3. Charges for **allergens, allergy testing** and **allergy injections**.

4. Charges for *Medically Necessary* local air or ground **ambulance** service to and from the nearest *Hospital* or nursing facility where *Emergency* care or treatment is rendered, or for services performed by a paramedic/EMT which eliminates the need for transfer to a *Hospital*. This Plan will only cover ambulance transportation when: 1) no other method of transportation is appropriate; 2) the services necessary to treat the *Sickness* or *Injury* are not available in the *Hospital* or nursing facility where the *Plan Participant* is an *Inpatient* ; and/or 3) the *Hospital* or nursing facility where the ambulance takes the *Plan Participant* is the nearest with adequate facilities.

5. Charges made by an ***Ambulatory Surgical Center*** or Minor Emergency Medical Clinic when treatment has been rendered.

   A Minor Emergency Medical Clinic is a free-standing facility which is engaged primarily in providing minor *Emergency* and episodic medical care to a *Plan Participant*. A board-certified *Physician*, a *Registered Nurse*, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular *Hospital* shall be excluded from the terms of this definition.

6. Charges for the cost and administration of **anesthetic** in conjunction with a covered surgical or medical procedure. Charges for the administration of anesthetics by a licensed Anesthesiologist or a Certified *Registered Nurse* Anesthetist (C.*R.N.*A.) are also covered.

7. Charges for the cost of treatment for **autism**, Asperger's Syndrome, and pervasive developmental disorder are covered if the treatment is provided by a psychiatrist, *Psychologist*, a *Social Worker* who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of any of those providers, or a professional working under the supervision of an *Outpatient* mental health clinic. This coverage will be provided in accordance with all the terms and conditions of Wis. Stat. 632.895(12m) including the definition of a licensed provider, covered items, limitations, exclusions, applicable dollar limits, etc.

8. Charges for the processing and administration of **blood or blood components**, including charges for the processing and storage of autologous blood.

9. Charges for **breast feeding** supplies, as well as basic counseling and general interventions to support and promote breast feeding are covered under the routine benefit.

10. **Breast reduction** when Medical Necessity is established and upon prior approval.

11. **Cardiac rehabilitation** programs limited to Phase I and II only.

12. Charges for **chemotherapy** or treatment. Pre-authorization is required for prescribed treatment.

13. Charges for scheduled **Childbirth** at home if under the supervision of an *Eligible Provider*.

14. **Chiropractic care** for treatment of a bodily *Injury* or *Sickness* is payable as shown in the Schedule of Benefits and subject to the *Maximum Benefit*. Services are limited to the treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere in the body.

15. Charges are covered for **cochlear implants** for children under age 18. Device, *surgery* for implantation of the device, and follow-up sessions to train on use of the device when *Medically Necessary* and Prior Authorized by the Health Plan payable as shown in the Schedule of Benefits and subject to the *Maximum Benefit*. A cochlear implant is a device implanted in the ear to facilitate communication for the profoundly hearing impaired. This coverage will be provided in accordance with the terms and conditions of Wis. Stat. 632.895(16) including the definition of a licensed provider, covered items, limitations, exclusions, etc.

16. Services performed as a result of a **complication**, regardless of whether the original service was a covered expense under the Plan.

17. The administration and supply for injectables, diaphragms, implants, IUD's, and office visits and laboratory work associated with **contraceptives** and sterilization procedures for females.

    Charges for oral contraceptives, NuvaRing, transdermal contraceptives, and Seasonique will be covered under the Prescription Drug plan.

18. **Cosmetic services** and supplies to repair a defect caused by an *Accidental Injury* or to repair a Dependent *Child*'s congenital anomaly.

19. Charges for services and supplies in relation to **diabetes** self-management programs. Such services must be *Medically Necessary* and prescribed by a *Physician.* Also, installation and use of an insulin infusion pump, glucose monitor, and other equipment or supplies (needles, syringes, lancets, clinitest, glucose strips and chem. strips may be covered under the *Prescription Drug* program) in the treatment of diabetes. Coverage for an insulin infusion pump is limited to the purchase of one (1) pump per *Calendar Year*.

20. Charges for **dialysis** in the home, as an *Inpatient* or at a *Medicare*-approved *Outpatient* dialysis center.

    For the first 90 days of outpatient dialysis (see below for home dialysis), the Plan will cover dialysis treatments at the applicable deductible and coinsurance as listed in the Schedule of Benefits. After 90 days, the plan will pay no more than $10,000 per month including dialysis treatments, supplies, and blood support products. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease.

    When dialysis treatments are administered at home, or for peritoneal dialysis, the plan will pay no more than $10,000 per month including dialysis treatments, supplies, and blood support products beginning the first month of treatment. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease.

    Dialysis: Dialysis services, equipment, supplies and medications are a covered expense under the plan as long as they are considered medically necessary (subject to the coverage as identified in the schedule of benefits) for the treatment of the patient.

21. The Plan provides benefits to a *Plan Participant* for *Prescription* ***Drugs*** **for treatment of HIV** infection in accordance with Section 632.895(9) of the Wisconsin Statutes. Drugs which satisfy all of the following are covered:

a. Is prescribed by the *Plan Participant*'s *Physician* for the treatment of HIV infection or any related condition arising from the HIV infection;
b. Is approved by the Federal Food and Drug Administration for the treatment of HIV infection or related condition; and,
c. If the drug is an investigational new drug, as provided in the statutes, is prescribed and administered according to approved protocol.

Coverage of such drugs is subject to all Plan provisions that apply to all other *Prescription Drug* coverage.

22. Charges for the rental, up to the purchase price, of a wheelchair, *Hospital* bed, iron lung, or other ***Durable Medical Equipment*** required for *Medically Necessary* temporary therapeutic use or the purchase of this equipment if economically justified, whichever is less. It is recommended that the *Plan Participant* obtain pre-approval of the purchase.

    Repairs and replacements for purchased *Durable Medical Equipment* will not be covered unless a repair is needed to restore proper function.

23. Charges for **electrocardiograms**, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by *Physician*s throughout the United States.

24. Covered services for **eye care** are limited to the vision examination and initial purchase of eyeglasses or contact lenses for aphakia, keratoconus and following cataract surgery. Payable as shown in the Schedule of Benefits and subject to the *Maximum Benefit*. Vision materials and services to vision materials are not covered under this benefit unless specifically provided. Maximum does not apply to Dependents through age 18.

25. **Foot care** charges for removal of corns, calluses, or complete removal of toenails; custom molded *Orthotics*; and services necessary in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy subject to limitations shown on the Schedule of Benefits.

26. Charges for **Health Risk Management** will be covered.

27. Charges for external **hearing aids** for children under age 18 are covered to a maximum of one (1) hearing aid per *Child*, per ear every three (3) years.

28. **Home Infusion *Therapy Services*** is treatment or service required for the administration of intravenous drugs or solutions, which meets the following guidelines:
    a. is required as a result of a *Sickness* or *Injury*; and
    b. prevents, delays, or shortens a *Hospital Inpatient Confinement* or *Skilled Nursing Facility Confinement*; and
    c. is documented in a Written plan of care; and
    d. is prescribed by the attending *Physician*; and is preapproved by the *Plan Administrator*

    Covered Charges will include charges by a *Home Health Care Agency* or home infusion company for the following services:
    a. intravenous chemotherapy;
    b. intravenous antibiotic therapy;

c. intravenous steroidal therapy;
d. intravenous pain management;
e. intravenous hydration therapy;
f. intravenous antiretroviral and antifungal therapy;
g. intravenous inotropic therapy;
h. total parenteral nutrition;
i. intravenous gamma globulin;
j. intrathecal and epidural;
k. blood and blood products;
l. injectable antiemetics; and
m. injectable diuretics.

The Home Infusion *Therapy Services* must be:

a. rendered in accordance with a prescribed treatment plan. The treatment plan must be: set up prior to the initiation of the Home Infusion Therapy Service; and prescribed by the attending *Physician*; and
b. preapproved by the *Plan Administrator* prior to the initiation of the Home Infusion Therapy Services, or in the event that services are required on a weekend, the *Plan Administrator* is notified the next following business day.
c. In addition, the attending *Physician* must certify that Home Infusion Therapy Services are necessary to prevent, delay or shorten *Hospital* Inpatient *Confinement* or *Skilled Nursing Facility Confinement*.

29. Benefits are provided for treatment up to the diagnosis of **infertility** only, including diagnostic testing and services.

30. Charges for **inhalation therapy**.

31. Charges for **injectable medications** and the administration of the injections in the doctor's office, *Hospital* or in the patient's home.

32. Charges for routine **mammograms** shall be covered according to the following guidelines:

    Age 0 – 39 – one (1) baseline if there is a family history of breast cancer in the *Plan Participant*'s immediate family (i.e., sister or mother)
    Age 40 and over – One (1) per *Calendar Year*

33. Charges for a *Medically Necessary* **mammoplasty** following a *Medically Necessary* mastectomy. Services include reconstruction of the breast on which the mastectomy has been performed and reconstruction of the other breast to produce symmetrical appearance. Breast prostheses, surgical brassieres (4 per Calendar Year maximum) and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan.

34. Charges for dressings, sutures, casts, splints, crutches, braces, trusses, custom molded foot orthotics, or other necessary **medical supplies**, with the exception of dental braces, orthopedic shoes, arch supports, lumbar braces, garter belts and similar items which can be purchased without a prescription (nor will they be covered with a prescription). However, elastic stockings (compression stockings) (2 per Calendar Year maximum) will be covered with a prescription.

35. Charges for an annual **Mental Health screening** for a *Plan Participant* to determine the need for treatment will be covered. For females covered by the Plan, at least one screening during a

Pregnancy for pre-partum depression and one screening within six (6) months after a live birth, stillbirth, or miscarriage for postpartum depression will be covered.

36. A certified Nurse **Midwife** means a person who is; (1) licensed as such and acting within the scope of the license; and (2) acting under proper direction furnished in affiliation with a Free Standing *Birthing Center*, *Hospital* or other qualified alternate facility. Charges made by a Free Standing *Birthing Center Incurred* by a person while the person's coverage is in force. All maternity related medical expenses made by a Qualified Practitioner at a *Hospital* or Free Standing *Birthing Center* or other qualified alternate facility. Benefits are payable as those for any other *Illness*. **Only one "facility" charge will be paid. For Example, if a *Birthing Center* is used and the mother is transferred to the *Hospital*, only one facility fee will be paid in connection with the use of a midwife.**

37. *Hospital* and *Physician* charges, including circumcision, in relation to the routine care of a ***Newborn*.** Routine *Newborn* care is covered under the baby's claim and not under the mother's claim.

    Group health plans generally may not, under Federal law, restrict benefits for any *Hospital* length of stay in connection with childbirth for the mother or *Newborn Child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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).

38. Care and treatment of *Morbid* ***Obesity***, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another *Sickness*. *Medically Necessary surgery* and nutritional counseling for *Morbid Obesity* will be covered if you:

    a. Weigh more than twice the ideal weight of a medium-frame person based on standard charts used by the life insurance industry.
    b. Have been considered morbidly obese by a *Physician* for at least five (5) years; and
    c. Non-surgical methods of weight loss have been supervised by a *Physician* for at least three (3) years without success.

    All of the above criteria must be satisfied before benefits will be available. Prior written approval is required for *Morbid Obesity surgery*. Surgical treatment is limited to one surgical procedure per *Lifetime*.

39. Charges for restorative or rehabilitative ***Occupational Therapy*** by a licensed *Occupational Therapist* due to a *Sickness* or *Injury* other than a functional nervous disorder, or due to *surgery* performed because of a *Sickness* or *Injury*. Covered expenses do not include recreational programs, maintenance therapy or supplies used in *Occupational Therapy*.

40. Charges for the following **oral *surgery*/dental services** whether performed by a *Dentist* or a medical doctor will be considered as eligible medical expenses:

    a. *Surgery* to correct accidental Injuries of the jaw, cheeks, lips, tongue, roof and floor of mouth, when such injuries are *Incurred* while a *Plan Participant* is covered under this Plan.

b. Reduction or manipulation of fractures of facial bones.
c. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth - such conditions require pathological examination.
d. Incision of the accessory sinuses, mouth, salivary glands or ducts.
e. Manipulation of dislocations of the jaw.
f. Surgical extraction of impacted teeth.
g. Excision of exostosis of the jaw and hard plate.
h. External incision and drainage of cellulitis.
i. Surgical exposure of impacted or unerupted teeth.
j. Apicoectomy – excision of apex of tooth root.
k. Gingivectomy – excision of loose gum tissue to eliminate infection.
l. Alveolectomy – the leveling of structures supporting teeth for the purpose of fitting dentures.
m. Frenectomy – incision of any midline fold of tissue between the jaws and lips and between the lower jaw and tongue.
n. Removal of retained (residual) root.
o. Gingival curettage under general anesthesia.
p. Apical curettage
q. Osseous *surgery* procedures which are related to the oral *surgery* procedures specified above.
r. Setting fractures of the jaws.
s. Extraction of seven (7) or more natural teeth at one time.
t. Services for the treatment of a dental *Injury* to a sound natural tooth, including but not limited to extraction, initial replacement, and related x-rays. The dental *Injury* and replacement must occur while you are covered under the Plan. Services must begin within 90 days after the date of the dental *Injury*. Benefits will be paid only for expense *Incurred* for the least expensive service that will, as determined by the *Claims Administrator*, produce a professionally adequate result.
u. *Hospital* or Ambulatory Surgery Center charges and anesthetics for Dental Care. Benefits are provided for *Hospital* or ambulatory surgery center charges *Incurred*, and anesthetics provided in conjunction with dental care that is provided to a *Plan Participant* in a *Hospital* or ambulatory surgery center, if any of the following apply:

    (1) The *Plan Participant* is a *Child* under the age of 5;
    (2) The *Plan Participant* has a chronic disability that meets all of the conditions under S.230.04(9) (a) 2.A.,b. and c., Wis. Statutes; or
    (3) The *Plan Participant* has a medical condition that requires hospitalization or general anesthesia for dental care.

No charges will be covered under the Medical Expense Benefits for dental and oral surgical procedures involving orthodontic care of teeth.

41. The initial purchase, fitting and repair of **Orthotic Appliances** such as braces, trusses, custom molded foot orthotics, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabled congenital condition or an *Injury* or *Sickness*.

    An orthotic appliance is an external device intended to correct any defect in form or function of the human body.

42. Charges for **osteotomies**.

43. **Over the Counter medications** are covered for non-sedating antihistamines (Allergy medications) and proton pump inhibitors (GI/ulcer medications) as approved by the *Prescription Drug* Plan Supervisor.

44. Charges for **oxygen** and other gases, and their administration.

45. Treatment or services rendered by a licensed *Physical Therapist* in a home setting or at a facility or institution which has the primary purpose of providing medical care for a *Sickness* or *Injury*. Charges for restorative or rehabilitative ***Physical Therapy*** due to a *Sickness* or *Injury*, or due to *surgery* performed because of a *Sickness* or *Injury* will be eligible.

46. Tests and studies required in connection with the *Plan Participant*'s admission for inpatient *surgery* are Covered Expenses payable at 100% if they are conducted within seven (7) days prior to admission. **Pre-admission testing** does not include tests or studies performed to establish a diagnosis. Benefits apply only if the services are not repeated when the *Plan Participant* is admitted to the *Hospital* as an *Inpatient*. If the *Inpatient* admission is canceled, either by the *Physician* or by the *Plan Participant*, the services are paid as an *Outpatient* claim if properly identified as a pre-admission testing service.

47. Eligible ***Pregnancy*** related expenses for a *Plan Participant* or a Dependent, including *Medically Necessary* amniocentesis tests, are considered the same as any other medical condition under the Plan. Surrogacy will also be considered a covered *Pregnancy*.

    Elective induced abortions will be covered. Treatments of complications that arise after an abortion are also covered.

    One (1) mental health screening during a *Pregnancy* for pre-partum depression and one (1) mental health screening six (6) months after a live birth, stillbirth, or miscarriage for postpartum depression will be covered.

    Group health plans generally may not under Federal law, restrict benefit for any *Hospital* length of stay in connection with childbirth for the mother or *Newborn Child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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).

48. Charges for ***Prescription Drug*s** are covered under the *Prescription Drug* card program that is not administered by the *Claims Administrator*. There are no benefits available for *Prescription Drug*s under this Plan other than through the *Prescription Drug* Expense Benefit unless stated otherwise. Please see the section titled "*Prescription Drug* Expense Benefit" or contact the Human Resouces/Benefits for further information.

49. **Private Duty Nursing** services of an actively practicing *Registered Nurse* (RN) or a *Licensed Practical Nurse* (*L.P.N.*) when ordered by a *Physician* providing such nurse does not ordinarily reside in the *Plan Participant*'s home and is not a member of his/her immediate family.

a. *Inpatient* Services. Those nursing services that the Plan determines are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the *Hospital*.
b. Home Services. Those nursing services that the Plan determines require the skills of an *R.N.* or *L.P.N.*

50. Initial purchase of **prosthetic devices** and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning bodily organ (excluding dental appliances). Replacement is a covered expense if due to pathological changes. Covered expense includes repair of the prosthetic device if not covered by the manufacturer or replacement if the appliance cannot be repaired to a serviceable condition.

51. Charges in relation to individual and group ***Psychiatric Care*** (treatment of a psychiatric condition, alcoholism, *Substance Abuse* or drug addiction). A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic depression. Benefits are available for *Inpatient*, *Outpatient*, and *Transitional Treatment*.

    Inpatient Treatment is care while the patient is in a *Hospital* or an *Inpatient* in a state licensed residential treatment facility. *Outpatient* Treatment means treatment performed by a *Hospital*, a licensed psychiatrist (M.D.), a licensed *Psychologist* (Ph.D.), or a state-licensed mental health or *Substance Abuse* treatment facility or any provider acting within the scope of their license. *Transitional Treatment* is care while the patient is partially confined in a licensed residential treatment facility.

    Collateral therapy performed with the family is a covered service.

    Note: *Prescription Drug*s for the treatment of *Psychiatric Care* are covered as any other *Prescription Drug* for the treatment of *Injury* or *Sickness*.

52. Charges for **radiation therapy** or treatment. Pre-authorization is required for prescribed treatment.

53. **Reconstructive *surgery*** to restore bodily function or correct deformity resulting from disease, trauma, or a previous therapeutic process that is a covered service under this Plan. This includes coverage for *surgery* subject to the provisions of the Women's Health and Cancer Rights Act. The disease, trauma, or therapeutic process must have occurred after the *Plan Participant*'s effective date and while the *Plan Participant* is continuously covered under the Plan. Transsexual *surgery* is excluded from coverage.

54. Charges for **respiratory therapy**.

55. Charges for **routine *Child Well-Care***. *Eligible Expenses* include those for office visits, developmental assessments, laboratory services, x-rays and immunizations, except mass immunizations. All *Well Child* immunizations as provided by CDC guidelines will be covered. Routine school examinations are limited to one (1) examination per *Calendar Year* per *Plan Participant*.

    Benefits are provided for blood lead tests for children under six (6) years of age, according to screening protocols established by the Department of Health and Family Services.

56. Charges for **routine physicals** for individuals. *Eligible Expenses* will include those for the office exam, any routine diagnostic services normally associated with a routine exam, and immunizations as provided by CDC guidelines, except mass immunizations.

    Care and treatment for adult obesity screening/counseling is covered under the routine benefit.

    When a claim is submitted, the Physician's office must code the claim to indicate Preventive Care or this Plan will consider the claim as treatment of Sickness or Injury.

57. Charges for **smoking cessation** office visits and counseling fees will be paid under the routine benefit. Smoking cessation drugs (both prescription and over-the-counter) will be covered according to the Prescription Drug Plan.

58. Charges for restorative or rehabilitative **speech therapy** by a licensed *Speech Therapist* due to a *Sickness* or *Injury*, or due to *surgery* performed because of a *Sickness* or *Injury*.

59. Charges in relation to a **sterilization** procedure. However, the reversal of a sterilization procedure is not covered. Charges in relation to female sterilizations will be covered under the preventive benefit.

60. Subject to the limitations, exclusions and conditions of the Plan, benefits are provided for any diagnostic procedures and *Medically Necessary* surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of **temporomandibular (*TMJ*) disorders**. Prior authorization is required for surgical or non-surgical *TMJ* services, but it is not required for diagnosis. Payable as shown in the Schedule of Benefits and subject to the *Maximum Benefit*.

61. Charges made by an ***Urgent Care Clinic*.**

62. Charges for **vision therapy**.

63. Charges for **x-rays, microscopic tests, and laboratory tests** along with the related radiology and pathology charges.

GENERAL LIMITATIONS

The following exclusions and limitations apply to *Expenses Incurred* by all *Plan Participants*:

1. **Allergies.** Therapy and testing for treatment of allergies, including but not limited to *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
    a. the American Academy of Allergy and Immunology; or
    b. the Department of Health and Human *Services* or any of its offices or agencies.

2. **Alternative care.** Charges for hypnotherapy, biofeedback, holistic medicine, massage therapy, Rolfing, health education, homeopathy, reiki, any type of goal oriented or behavior modification therapy, myo-functional therapy, and programs intended to provide complete personal fulfillment or harmony.

3. **Cardiac rehabilitation.** Services and charges for Phase III and Phase IV cardiac rehabilitation.

4. ***Chelation Therapy*.** Charges in relation to *Chelation Therapy* except in the treatment of heavy metal poisoning.

5. ***Close Relative*.** Charges for services rendered by a *Physician*, nurse, or licensed therapist if such *Physician*, nurse, or licensed therapist is a *Close Relative* of the *Plan Participant*, or resides in the same household of the *Plan Participant*.

6. **Copy charges.** Charges for the photocopying of medical records.

7. ***Cosmetic Procedure*s.** Charges in connection with the care or treatment of, or *surgery* performed for, a *Cosmetic Procedure*. Additionally, charges related to surgical treatment of scarring secondary to acne or chicken pox to include, but not be limited to dermabrasion, chemical peel, salabrasion, and collagen injections, unless causing pain. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an *Accidental Injury* or disfiguring disease (does not include scarring due to acne or chicken pox), or when rendered to correct a congenital anomaly (i.e., a birth defect) of a *Plan Participant*. Pre-authorization is recommended.

8. **Court costs.** Charges for court costs, penalties, interest upon judgment, investigative expenses, administrative fees or legal expenses.

9. **Court ordered services.** Services and supplies related to court ordered treatment; also coverage for court ordered examinations to rule on voluntary or involuntary commitment or detention.

10. ***Custodial Care*.** Services or supplies provided mainly as a rest cure, maintenance or *Custodial Care*. Additionally, *Expenses Incurred* for accommodations (including *Room and Board* and other institutional services) and nursing services for a *Plan Participant* because of age or a mental or physical condition primarily to assist the *Plan Participant* in daily living activities will be considered *Custodial Care*. The fact that the *Plan Participant* is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying.

11. **Dental services.** Dental services or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to implants and related procedures, and orthodontic

procedures, unless specifically provided under this Plan; services for orthognathic *surgery* and osteotomy procedures of the maxilla or mandible, and LeFort I, II and III procedures are not covered.

12. **Developmental delays.** Services to treat developmental delays. Also care and treatment for learning disorders, or charges for remedial education, and charges *Incurred* for services (other than diagnostic services) for mental retardation or for non-treatable mental deficiency. The cost of treatment for autism, Asperger's Syndrome, and pervasive developmental disorder not otherwise specified are covered if the treatment is provided by a psychiatrist, *Psychologist*, a *Social Worker* who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of any of those providers, or a professional working under the supervision of an *Outpatient* mental health clinic.

13. **Education and/or training.** Charges for services or supplies in connection with education or training except as specifically covered elsewhere in this Plan.

14. **Excess.** Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the *Usual, Reasonable and Customary* amount, or are for services not deemed to be *Reasonable* or *Medically Necessary*, based upon the *Plan Administrator*'s determination as set forth by and within the terms of this document..

15. ***Experimental* and/or Investigational procedures.** Charges for "*Experimental*" and/or "Investigational" ("*Experimental*") shall mean services or treatments that:
    1. are not accepted as standard medical treatment for the *Illness*, disease or *Injury* being treated by *Physician*s or most practitioners practicing the suitable medical specialty;
    2. are the subject of scientific or medical research or study to determine the item or regimen's effectiveness and safety;
    3. have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including but not limited to the Federal Department of Health and Human Services, Food and Drug Administration, or any comparable state government agency, and the Federal Health care Finance Administration as approved for reimbursement under *Medicare* Title XVIII; or
    4. are performed subject to the *Plan Participant's* informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

    All phases of clinical trials shall be considered *Experimental*.

16. **Eye care.** Services to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically indicated in Other Covered Expenses. Radial keratotomy, LASIK or other eye *surgery* to correct nearsightedness, farsightedness, astigmatism, or vision therapy (orthoptics) are not covered.

17. **False statement.** The Plan relies on the completeness and truthfulness of the information required to be given. If a *Plan Participant* has made any false statement or misrepresentations, or has failed to disclose or conceal any material fact, the Plan will be entitled to terminate coverage and not make benefit payments.

18. **FDA.** Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 501K, ANDA, BLA, or PLA.

19. **Foot care.** Services for routine palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except for capsular or bone *surgery*), calluses, toe nails (except for the complete removal of toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet except as specifically listed as covered.

20. **Foreign travel.** If a *Plan Participant* receives medical treatment outside of the United States or its territories, benefits shall be provided for those charges to the extent that the services rendered are included as covered expenses in the Plan, and provided the *Plan Participant* did not travel to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

    Additionally, charges for such treatment may not exceed the limits specified herein as *Usual, Reasonable and Customary* in the area of residence of the *Plan Participant* in the United States. Fees and charges exceeding *Usual, Reasonable and Customary* shall be disallowed as ineligible charges. Charges equal to or less than *Usual, Reasonable and Customary* shall be considered. In no event shall benefit payment exceed the actual amount charged.

21. **Gender identification problems.** Charges related to counseling for persons suffering from gender identification problems, or services or supplies related to the performance of gender transformation procedures.

22. **Genetic testing.** For genetic testing, including, but not limited to tests which use DNA to determine the presence of a genetic disease or disorder.

23. **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

24. **Grandchild.** Charges for a grandchild of a *Plan Participant* or covered Spouse unless the grandchild satisfies the definition of eligible Dependent *Child* under this Plan.

25. **Hair.** Charges for wigs and artificial hair pieces, and care and treatment of hair loss, hair transplants or any drugs that promise hair growth, whether or not prescribed by a *Physician.*

26. **Hearing aids.** For hearing aids, whether removable or surgically implanted, routine hearing exams, and the fitting or repair of hearing aids, except for *Child*ren under the age of 18. See the covered services section for coverage of cochlear implants and hearing aids for *Child*ren under the age of 18.

27. **Hearing therapy.** Charges for hearing therapy.

28. ***Hospital* Employees.** Professional services billed by a *Physician* or nurse who is an employee of a *Hospital* or Skilled Nursing or Extended Care Facility and paid by the *Hospital* or facility for the services.

29. ***Hospital*ization for convalescent or rest care.** Charges for *Hospital*ization when such *Confinement* occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with an actual *Sickness* or *Injury*.

30. **Illegal act.** Any expense due to commission or attempt to commit a civil or criminal battery or felony; where person is charged and convicted, unless due to a medical condition, whether mental or physical.

31. **Illegal drugs or medications.** Charges in relation to use of illegal drugs or medications.

32. **Impotence.** Services related to the treatment and/or diagnosis of sexual dysfunction/impotence, unless if due to bodily *Injury* or *Mental Disorder* or another *Sickness*.

33. **Incarcerated.** Charges for services or supplies received while incarcerated in a penal institution or in legal custody.

34. **Infertility.** All fertility testing or services (other than diagnostic testing or services), including any artificial means to achieve *Pregnancy* or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking.

35. **Injections**. For injection of a medication except as specifically provided.

36. ***Inpatient* concurrent services.** Charges for *Inpatient* concurrent services of *Physician*s, unless there is a clinical necessity for supplemental skills and two or more *Physician*s attend the patient for separate conditions during the same *Hospital* admission.

37. ***Inpatient Hospital* admissions.** Charges for *Inpatient Hospital* admissions primarily for x-ray and radiation therapy. For *Inpatient Hospital* admissions which are primarily for *Physical Therapy*, speech or *Occupational Therapy*.

38. **Maintenance therapies.** Charges for maintenance therapies.

39. **Marital and/or family counseling.** Charges for marriage and sex counseling, behavior training, conduct disorders and related family counseling.

40. ***Medicare*.** For the portion of the services for which a *Plan Participant* is entitled to payment under *Medicare* Part A and B, provided *Medicare* is the *Plan Participant*'s primary payer. *Medicare* is primary except where it is secondary payer by law. When *Medicare* is primary payer, and if the *Plan Participant* does not apply for *Medicare* or does not comply with *Medicare* requirements, the benefits payable under the Plan will be reduced by the amount *Medicare* would have paid if the *Plan Participant* had enrolled or complied. No benefits are provided for services or supplies which *Medicare* considers not *Reasonable* or not *Medically Necessary*.

41. **Military.** Services furnished for a military service connected *Sickness* or bodily *Injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs.

42. **Motor vehicles.** Charges related to the rental or purchase of a motor vehicle, or charges associated with the conversion of a motor vehicle to accommodate a disability.

43. **No charge.** Expenses for which a charge would not ordinarily be made in the absence of this coverage.

44. **No fault.** 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 includes, without limitation, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

45. **Non-compliance.** *Expenses Incurred* due to or as a consequence or non-compliance with any applicable State or Federal statutes or regulations.

46. **Non-Emergency *Hospital* admission.** Care and treatment billed by a *Hospital* for a non-medical *Emergency* admission on a Friday or a Saturday. This does not apply if *surgery* is performed within 24 hours of admission.

47. **Non-prescription medications.** Non-prescription medicines, vitamins, nutrients, and nutritional supplements, even if prescribed or administered by a *Physician*. Prenatal vitamins and Prescription vitamins are covered under the Prescription Drug Benefit Plan.

48. **No Legal Obligation.** Charges are provided to a *Plan Participant* for which the Provider of a service customarily makes no direct charge, or for which the *Plan Participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, Company or any other entity except the *Plan Participant* or this benefit plan, ***may be liable*** for necessitating the fees, care, supplies, or services.

49. **Not *Medically Necessary*.** Care and treatment that is not *Medically Necessary*.

50. **Not recommended by a *Physician*.** Charges that are not recommended and approved by a *Physician*, or are not recognized by the American Medical Association as generally accepted and *Medically Necessary* for the diagnosis and/or treatment of an active *Sickness* or *Injury*; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

51. **Nursing services rendered by someone other than a *Registered Nurse*.** Charges for professional nursing services if rendered by someone other than a *Registered Nurse* (*R.N.*) or *Licensed Practical Nurse* (*L.P.N.*), unless such care was vital as a safeguard of the *Plan Participant's* life, and/or unless such care is specifically listed as a covered expense elsewhere in the Plan. In addition, the Plan will not cover certified *Registered Nurses* in independent practice (other than an anesthetist). This exclusion does not apply to private duty nurses as addressed elsewhere in this Plan.

52. **Nutritional consultation.** Nutritional consultation or instruction, service or supplies for educational, vocational or training purposes, except as specifically included as a covered benefit.

53. **Obesity.** Services for weight loss or control unless for diagnosed *Morbid Obesity*. For diagnosed *Morbid Obesity*, surgical treatment is limited to one (1) surgical procedure per *Lifetime*.

54. **Occupational.** Any bodily *Injury* or *Sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain from which:

    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or

b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased.

55. **Orthopedic shoes.** Corrective shoes and *Orthotics*, unless it is part of an orthopedic leg brace except as specifically listed as covered.

56. **Other coverage.** Received from a dental or medical department maintained by or on behalf of an *Employer* (other than Walworth County), a mutual benefit association, labor union, trust or similar person or group.

57. **Personal comfort.** Charges for services or supplies which constitute beautification items; for television or telephone use; for nutritional supplements; or in connection with *Custodial Care*, education or training, or expenses actually *Incurred* by other persons. Charges for the purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, allergy-free pillows, blankets or mattress covers, electric heating units, swimming pools, orthopedic mattresses, vibratory equipment, elevators, stair lifts, exercise equipment, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, non-*Hospital* adjustable bed, non-*Prescription Drug*s and medicines, first aid supplies and other such equipment.

58. **Penile prosthesis.** Charges for penile prosthesis/implants and any charges relating thereto, unless related to an organic disorder.

59. **PIP.** *Sickness* or bodily *Injury* for which medical payments/personal *Injury* protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this Plan did not exist.

60. **Plan design exclusions.** Charges excluded by Plan design as mentioned in this document.

61. **Previous plan.** *Expenses Incurred* for which you are entitled to receive benefits under your previous dental or medical plan.

62. **Radial keratotomy.** Charges in relation to radial keratotomy, Lasik, corneal modulation, refractive keratoplasty or any similar procedure.

63. **Radioactive contamination.** Charges *Incurred* as a result of the hazardous properties of nuclear material.

64. **Recreational or educational therapy.** Charges for services or supplies for recreational or educational therapy or forms of non-medical self-help or self-cure, including any related diagnostic testing, training for active daily living skills; or health club memberships.

65. **Replacement blood.** Blood or blood plasma that is replaced by or for the patient (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience or for a substantially equivalent supply).

66. **Routine medical examinations.** Charges *Incurred* for routine medical examinations or care,

routine health checkups, or immunizations, except as specifically shown as a covered expense elsewhere in the Plan.

67. **Self-inflicted *Injury*.** Charges in relation to intentionally self-inflicted *Injury* or self-induced *Sickness*. This exclusion does not apply (a) if the *Injury* resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

68. **Services before or after coverage.** Charges *Incurred* prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

69. **Sex change.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, *surgery*, medical or psychiatric treatment.

70. **Sexual dysfunction**. Services for treatment of sexual dysfunction not related to organic disease.

71. **Sleep disorders.** Care and treatment for sleep disorders, unless deemed *Medically Necessary*. **NOTE: If deemed *Medically Necessary*, rental or purchase of applicable *Durable Medical Equipment* or treatment plans must be pre-authorized.** Additionally, purchase of *Durable Medical Equipment* will only be considered payable by the Plan, after a period of 90 days during which the equipment has been rented.

72. **Smoking cessation.** Smoking cessation products, except as specifically shown as a covered expense elsewhere in the Plan.

73. **Subrogation, Reimbursement, and/or Third Party Responsibility**. Charges for an *Injury* or *Sickness* not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

74. **Splints or braces for non-medical purposes.** Charges for splints or braces for non-medical purposes (i.e., support worn primarily during participation in sports or similar physical activities).

75. **Surgical sterilization reversal.** Charges related to or in connection with the reversal of a sterilization procedure.

76. **Telephone consultations.** Charges for failing to keep an appointment, telephone consultations, internet and e-mail consultations, the completion of a claim form, an itemized bill or providing necessary medical records or information in order to process a claim.

77. **Third Party examination.** Non-medical evaluations for employment, marriage license, judicial or administrative proceedings, school, travel or purchase of insurance, etc. except as specifically provided under routine benefits.

78. **Travel expenses.** Charges for travel or accommodations unless specifically covered under a transplant or other policy elsewhere in this Plan, whether or not recommended by a *Physician*, except for ambulance charges as defined as a covered expense.

79. **Vocational rehabilitation.** Charges for vocational rehabilitation and service for educational or vocational testing or training.

80. **War.** Charges as a result of active participation in war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

PRESCRIPTION DRUG EXPENSE BENEFIT

Your Medical Identification (ID) card includes a section for your prescription benefits. It will show your Pharmacy Benefit Manager logo and contact number, pharmacy ID number, and pharmacy group number. Eligibility and benefit information is available online.

A directory of participating pharmacies is available on the Drug Card's web site. A print version is also available upon your request. The pharmacy directory is a separate document from this Plan. The directory contains the name, address and phone number of the pharmacies that are part of the Drug Card.

Step Therapy

In addition to promoting generic and *Formulary* brand use, the Plan includes a Step Therapy program administered by The *Prescription Drug* Plan Supervisor, unless otherwise provided by collective bargaining agreement. This program contains specific drugs that may have high-cost brand, low-cost generic drugs and over-the-counter (OTC) options only as specified.

Points of Step Therapy:

- Means that you may be required to use equally safe and effective generic or OTC drugs to treat your medical condition before authorization is granted for a more costly brand or non-preferred generic drug.
- All failure of previous steps in the program must be either in the patient history in the *Prescription Drug* Plan Supervisor claims database, or notes from the patient's medical chart must be FAXED to the *Prescription Drug* Plan Supervisor showing failure.
- All Prior Authorization forms are available by contacting the *Prescription Drug* Plan Supervisor.
- Failure on the part of the *Physician* to fill out the Prior Authorization form completely or to not attach chart notes showing past failures may result in a delay in the *Plan Participant*'s therapy.
- There will be savings for both you and your *Employer* if you follow Step Therapy recommendations.

Covered drugs

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

How to Use the *Prescription Drug* Card

Present the ID card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the co-pay showing in the Schedule of Benefits.

If you are without your ID card or at a *Non-Participating Pharmacy*, you may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from your *Employer*.

Mail Order Drug Service

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

The co-pay for mail order prescription is show in the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card's web site or from your *Employer*. All prescriptions will be mailed directly to your home.

Prior Authorization

There are categories of prescriptions that will require a prior authorization process with your doctor and the *Prescription Drug* Plan Supervisor. Please contact the Pharmacy Benefit Manager located on your ID card for additional information.

Additional *Prescription Drug* Benefit Information

When a participating pharmacy is used and you do not present your I.D. card to the participating pharmacy at the time of purchase, you must pay the pharmacy the full retail price and submit the pharmacy receipt to the *Prescription Drug* Plan Supervisor at the address listed below. You will be reimbursed at 100% of billed charges after the charge has been reduced by the applicable *Co-payment*s.

When a *Non-Participating Pharmacy* is used, you must pay the pharmacy the full price of the drug and submit the pharmacy receipt to the *Prescription Drug* Plan Supervisor at the address listed below. You will be reimbursed for the Plans cost for the drug reduced by the applicable *Co-payment*.

Mail a *Prescription Drug* Reimbursement Form (available from the *Prescription Drug* Plan Supervisor or your Human Resouces/Benefits) and Pharmacy receipts to the address listed on the Reimbursement form.

*A 90-day supply of certain *Prescription Drug*s on the Maintenance Drug list may be available at the retail pharmacy. If the prescription is on the eligible drug list, 2.5 *Co-payment*s will be required for a 90-day supply and the attending/prescribing *Physician* must have authorized a 90-day quantity. A 90-day supply of a non-*Formulary* brand name prescription will require 3 *Co-payment*s.

Coordination of Benefits applies to the Pharmacy Benefits under this Plan.

TERMINATION OF COVERAGE

Plan Participant/Retiree Termination

Plan Participant/Retiree *Coverage* will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The end of the calendar month immediately following: the month in which the individual's employment with the *County* is terminated, or, the month in which the individual ceases to qualify as a *Plan Participant*/Retiree eligible for coverage.

2. The end of the month for which the last contribution is made if the *Plan Participant*/Retiree fails to make any required contributions when due.

3. The date the Plan is terminated; or with respect to any *Plan Participant* benefit of the Plan, the date of termination of such benefit.

4. The end of the month the *Plan Participant*/Retiree enters military duty, except for temporary duty of 30 calendar days or less (or as required under USERRA).

5. The end of the month following the *Plan Participant*'s/Retiree's death.

6. The date the *Plan Participant*/Retiree knowingly misrepresents/falsifies information to the Plan.

7. For Walworth County *Employees* who work Lakeland School, coverage will continue on the same basis as an active *Plan Participant* through the summer provided the *Employee* has paid their *Employee* portion of the plan cost for this period. If an *Employee* should not return for the next semester/term, coverage will terminate the end of the month following their last day of work.

Dependent Termination

Dependent Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The end of the month the Dependent ceases to be an eligible Dependent as defined in the Plan.

2. The end of the calendar month immediately following: the month in which the *Employee*'s employment with the *County* is terminated, or, the month in which the *Employee*/Retiree ceases to qualify as eligible for coverage.

3. The end of the month for which the last contribution is made if the *Plan Participant*/Retiree fails to make any required contributions when due.

4. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit.

5. The date the Dependent enters military duty.

6. The date the Dependent becomes covered under this Plan as an individual *Plan Participant*.

7. The end of the month following the *Plan Participant*'s/Retiree's death.

8. In the event of a divorce, the Spouse will be terminated the end of the month the divorce decree is finalized.

If your contributions have been taken on a pre-tax basis and you wish to terminate coverage during the year, but do not have a qualifying change in status in accordance with IRS regulations addressing Section 125 Plan Elections, you will continue to pay your pre-tax contributions until the end of the plan year. If you wish to have your contributions taken on an after-tax basis, please contact the Human Resource Department for a Pre-Tax Contribution Waiver form.

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

Federal law may affect your coverage under this Plan. The *Medicare* as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to *Employees* (or their spouses) over age 65 were added to the Social Security Act and the Internal Revenue Code.

Generally, the health care plan of an *Employer* that has at least 20 *Employee*s must operate in compliance with these rules in providing plan coverage to *Plan Participant*s who have "current employment status" and are *Medicare* beneficiaries, age 65 and over.

Persons who have "current employment status" with an *Employer* are generally *Employees* who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an *Employer* for up to six (6) months; or
- Individuals who retain employment rights and have not been terminated by the *Employer* and for whom the *Employer* continues to provide coverage under this Plan (for example, *Employees* who are on an approved leave of absence).

If you are a person having "current employment status" who is age 65 and over (or the dependent spouse age 65 and over of an *Employee* of any age), your coverage under this Plan will be provided on the same terms and conditions as are applicable to *Employees* (or dependent spouses) who are under the age of 65. Your rights under this Plan do not change because you (or your dependent spouse) are eligible for *Medicare* coverage on the basis of age, as long as you have "current employment status: with your *Employer*.

You have the option to reject plan coverage offered by your *Employer*, as does any eligible *Employee*. If you reject coverage under your *Employer*'s plan, coverage is terminated and your *Employer* is not permitted to offer you coverage that supplements *Medicare* covered services.

If you (or your dependent spouse) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to *Medicare* when you have elected coverage under this Plan and have "current employment status". If you have any questions how coverage under this Plan relates to *Medicare* coverage, please contact your *Employer*.

EXTENSION OF BENEFITS

Benefits after Termination of Coverage

If coverage terminates during a *Plan Participant*'s *Confinement*, benefits will continue to be available to the *Plan Participant* for a maximum period of 30 consecutive days after the date of termination. In no event will benefits be available to the *Plan Participant* after the date the *Plan Participant* is discharged from the institution in which he was confined (unless the *Plan Participant* is *Totally Disabled* at the time of termination), or the fulfillment of any total aggregate allowance or time limitation set forth in the Plan, whichever occurs first.

If on the date of termination a *Plan Participant* is *Totally Disabled* and under the care of a *Physician*, such *Plan Participant* is entitled to a continuation of benefits pertaining solely to the *Illness* which caused such disability, subject to all limitations, exclusions and conditions of the Plan. During such *Total Disability* while under such care, benefits will continue until the earlier of:

1. the expiration of a 12 consecutive month period immediately following the termination of coverage;

2. the date on which the *Plan Participant* becomes covered under other coverage; or,

3. the fulfillment of any total aggregate allowance or time limitation set forth in the Plan.

This continuation of benefits provision for *Total Disability* does not apply if coverage terminated due to the failure of the *Plan Participant*/Retiree to make any required premium contribution.

If any care is required by a *Plan Participant* after his/her rights to benefits have terminated, the *Expenses Incurred* for such care will be the sole responsibility of the *Plan Participant* or the person legally responsible for his/her care.

Donation of Vacation/Holiday Time Transfer Donor Program

This program is set forth and administered through the *Employer* and is a process whereby one *Employee* may donate vacation/holiday time to a fellow *Employee*.

Donor Program Eligibility:

A. *Employee*s may participate in the donor program. "Participate" means to either donate or receive vacation or holiday hours. Donated hours shall be in increments of eight (8) hours.

B. An *Employee* shall be eligible to receive donated hours when all of the following criteria are met;

1. The *Employee* is on an approved medical leave due to a serious health condition of himself or herself, or the *Employee's* spouse, *Child*, or parent;
2. The *Employee* has exhausted all of his or her available accrued benefits;
3. The *Employee's* absence exceeds 60 calendar days.

Limitations on Donated Hours:

A. An *Employee*'s decision to donate hours may not be revoked by the donating *Employee*. Any hours donated in excess of the eligible *Employee's* needs shall be returned to the donor. Donated hours will be used in a First In, First Out fashion.

B. The *Employee's* extended pay status under the donor program shall end on the earlier of:

   1. The date the *Employee* is eligible to apply for and receive long-term disability benefits, regardless of whether the *Employee* was enrolled for the long-term disability benefits or not.
   2. The date of the *Employee's* retirement or disability annuity, or upon death.
   3. Ninety calendar days from the date the *Employee's* leave began.

C. Donated hours shall be applied at the recipient's prevailing Full-Time employment rate continuous from the date that the *Employee*'s personal accrued benefits were exhausted. Donated hours shall be paid at the recipient's rate of pay.

D. The recipient shall not accrue new personal time-off benefits when receiving donated hours. Donated hours shall be counted as paid time for the purpose of determining the termination of *county*-paid insurance benefits.

For further information regarding this program see the Human Resources/Benefits Department.

Special Provisions for Not Being Inactive Status

The following apply to absences from work not subject to *Family and Medical Leave Act (FMLA)* guidelines. If you and/or the *County* continue to pay required plan contributions, your coverage will remain in force to the end of the calendar month for which premiums were paid. *County* policy and/or an applicable collective bargaining agreement shall determine the period of time for which the *County* will continue to contribute towards the cost of the plan. If you do not pay your portion of the plan cost, your coverage under the Plan may, with notice to you, be terminated

Reinstatement of Coverage Following Inactive Status

If your coverage under the Plan was terminated due to your inactive status, and you are now returning to work, your coverage will be reinstated effective immediately on the day you return to work only as specified under the terms and conditions of your collective bargaining agreement. If you are not covered by a collective bargaining agreement, any applicable *County* Ordinance or *County* approved leave agreements would apply. Eligibility waiting periods and preexisting condition limitations will be imposed only to the extent they were applicable prior to your inactive status. Any accumulated *Calendar Year* maximums will apply.

If your coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your coverage is effective immediately on the day you return to work. Eligibility waiting periods and preexisting condition limitations will be imposed only to the extent they were applicable prior to the period of service in the uniformed services. Any accumulated *Calendar Year* maximums will apply.

***Family and Medical Leave Act (FMLA)* Provision**

Regardless of the established leave policies mentioned elsewhere in this document, this Plan shall at all times comply with the *Family and Medical Leave Act* of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the *Family and Medical Leave Act*, the *Employer* will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered *Employee* had been continuously employed during the entire leave period.

If Plan coverage terminates during the *FMLA* leave, coverage will be reinstated for the *Employee* and his or her covered Dependents if the *Employee* returns to work in accordance with the terms of the *FMLA* leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the *FMLA* leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the *Employee* and/or his or her Dependents when Plan coverage terminated.

Employee eligibility requirements, the obligations of the *Employer* and *Employee* concerning conditions of leave, and notification and reporting requirements are specified in the *FMLA*. Any plan provisions which conflict with the *FMLA* are superseded by the *FMLA* to the extent such provisions conflict with the *FMLA*. *Employees* with questions concerning any rights and/or obligations should contact the *Plan Administrator* or their *Employer*.

The *FMLA* Act generally provides for 12 weeks of leave for personal *Illness* or *Injury* or that of a family member. However, there are special time restrictions for the family of Military *Plan Participants* who were injured during active duty in the armed forces:

1. **Leave During Family Member's Active Duty** -- *Employees* who have a spouse, parent, or *Child* who is on or has been called to active duty in the Armed Forces may take up to 12 weeks of *FMLA* leave yearly when they experience a "qualifying exigency."
2. **Injured Service member Family Leave** -- *Employees* who are the spouse, parent, *Child*, or next of kin of a service member who *Incurred* a serious *Injury* or *Illness* on active duty in the Armed Forces may take up to 26 weeks of leave to care for the injured service member in a 12-month period (in combination with regular *FMLA* leave).

Uniformed Services Employment and Reemployment Rights Act (USERRA)

***Plan Participants* on Military Leave**

Plan Participants going into or returning from military service may elect to continue plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to *Plan Participants* and their Dependents covered under the plan before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be the lesser of:

    - The 24-month period beginning on the date on which the person's absence begins; or
    - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

2. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the plan, except that a person on active duty for 30 days or less cannot be required to pay more than the *Plan Participant's* share, if any, for the coverage.

3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any *Illness* or *Injury* determined by the Secretary of Veterans Affairs to have been *Incurred* in, or aggravated during, the performance of uniformed service.

***COBRA* Extension of Benefits**

Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (*COBRA*), certain *Plan Participants* and their families covered under the Walworth County Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "*COBRA* continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform *Plan Participant*s and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of *COBRA*, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The *Plan Administrator* is Walworth County Human Resources/Benefits, 100 West Walworth St., P.O. Box 1001, Elkhorn, Wisconsin 53121, (262) 741-7950. *COBRA* continuation coverage for the Plan is administered by Walworth County Human Resources/Benefits, 100 West Walworth St., P.O. Box 1001, Elkhorn, Wisconsin 53121, (262) 741-7950. Complete instructions on *COBRA*, as well as election forms and other information, will be provided by the *Plan Administrator* to *Plan Participant*s who become Qualified Beneficiaries under *COBRA.*

***COBRA* Continuation Coverage In General** *COBRA* continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *Plan Participant*s and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to *COBRA* continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active *Plan Participants* who have not experienced a Qualifying Event (in other words, similarly situated non-*COBRA* beneficiaries).

Qualified Beneficiary Defined In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered *Plan Participant*, the Spouse of a covered *Plan Participant*, or a Dependent *Child* of a covered *Plan Participant*. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any *Child* who is born to or placed for adoption with a covered *Plan Participant* during a period of *COBRA* continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or

failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered *Plan Participant*" includes not only common-law *Plan Participants* (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the *Employer* sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered *Plan Participant* is attributable to a period in which the individual was a nonresident alien who received from the individual's *Employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent *Child* of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a *Child* who is born to or placed for adoption with a covered *Plan Participant* during a period of *COBRA* continuation coverage) must be offered the opportunity to make an independent election to receive *COBRA* continuation coverage.

Qualifying Events Explained A Qualifying Event is any of the following if the Plan provided that the *Plan Participant* would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of *COBRA* continuation coverage:

1. The death of a covered *Plan Participant*.

2. The termination (other than by reason of the *Plan Participant's* gross misconduct), or reduction of hours, of a covered *Plan Participant's* employment.

3. The divorce or legal separation of a covered *Plan Participant* from the *Plan Participant's* Spouse.

4. A covered *Plan Participant's* enrollment in any part of the *Medicare* program.

5. A Dependent *Child*'s ceasing to satisfy the Plan's requirements for a Dependent *Child* (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered *Plan Participant*, or the covered Spouse or a Dependent *Child* of the covered *Plan Participant*, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the *Employer*, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under *COBRA* if all the other conditions of the *COBRA* are also met. For example, any increase in contribution that must be paid by a covered *Plan Participant*, or the Spouse, or a Dependent *Child* of the covered *Plan Participant*, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the *Family and Medical Leave Act* of 1993 ("*FMLA*") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a *Plan Participant* does not return to employment at the end of the *FMLA* leave and all other *COBRA* continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of *FMLA* leave and the applicable

maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *Plan Participant* and family members will be entitled to *COBRA* continuation coverage even if they failed to pay the *Plan Participant* portion of premiums for coverage under the Plan during the *FMLA* leave.

Procedure for obtaining *COBRA* continuation coverage The Plan has conditioned the availability of *COBRA* continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Election of *COBRA* and Length of Election period The election period is the time period within which the Qualified Beneficiary can elect *COBRA* continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect *COBRA* continuation coverage.

Note: If a covered *Plan Participant* who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a Federal law called the Trade Act of 2002, and the *Plan Participant* and his or her covered Dependents have not elected *COBRA* coverage within the normal election period, a second opportunity to elect *COBRA* coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the *Plan Administrator* for further information.

Notifying the *Plan Administrator* of the occurrence of a Qualifying Event. The Plan will offer *COBRA* continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely notified that a Qualifying Event has occurred. The *Employer* (if the *Employer* is not the *Plan Administrator*) will notify the *Plan Administrator* of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the *Plan Participant*,
3. commencement of a proceeding in bankruptcy with respect to the *Employer*, or
4. enrollment of the *Plan Participant* in any part of *Medicare*.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the *Plan Participant* and spouse or a Dependent *Child*'s losing eligibility for coverage as a Dependent *Child*), you or someone on your behalf must notify the *Plan Administrator* or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the *Plan Administrator* or its designee during the 60-day notice period, any spouse or Dependent *Child* who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the *COBRA* Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Human Resouces/Benefits
Walworth County
100 West Walworth St.
P.O. Box 1001
Elkhorn, Wisconsin 53121
(262) 741-7950 phone
(262) 741-7963 fax

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage;
- the **name and address of the *Plan Participant*** covered under the plan;
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**; and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, such as in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives *timely notice* that a Qualifying Event has occurred, *COBRA* continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect *COBRA* continuation coverage. Covered *Plan Participants* may elect *COBRA* continuation coverage for their spouses, and parents may elect *COBRA* continuation coverage on behalf of their *Child*ren. For each Qualified Beneficiary who elects *COBRA* continuation coverage, *COBRA* continuation coverage will begin on the date that plan coverage would otherwise have been lost (if, under your plan, the *COBRA* period begins on the date of the Qualifying Event, even though coverage actually ends later. If the *Plan Participant* or their spouse or Dependent *Child*ren do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Waiver of a Qualified Beneficiary's election rights before end of period If, during the election period, a Qualified Beneficiary waives *COBRA* continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of *COBRA* continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

Termination of a Qualified Beneficiary's *COBRA* continuation coverage. During the election period, a Qualified Beneficiary may waive *COBRA* continuation coverage. Except for an interruption of coverage in connection with a waiver, *COBRA* continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the *Employer* ceases to provide any group health plan (including a successor plan) to any *Plan Participant.*

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to *any Pre-existing Condition*, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the *Medicare* program (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-*COBRA* beneficiaries, such as for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make *COBRA* continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Maximum coverage periods for *COBRA* continuation coverage. The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered *Plan Participant*'s enrollment in the *Medicare* program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered *Plan Participant* ends on the later of:

    a. 36 months after the date the covered *Plan Participant* becomes enrolled in the *Medicare* program; or

    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered *Plan Participant*'s termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a *Child* born to or placed for adoption with a covered *Plan Participant* during a period of *COBRA* continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of *COBRA* continuation coverage during which the *Child* was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Circumstances when the maximum coverage period be expanded. If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the *COBRA* maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The *Plan Administrator* must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the *COBRA* Administrator.

Disability extension. A disability extension will be granted if an individual (whether or not the covered *Employee*) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered *Plan Participant's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of *COBRA* continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the *Plan Administrator* with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the *COBRA* Administrator.

Payment for *COBRA* continuation coverage. For any period of *COBRA* continuation coverage under the Plan, qualified beneficiaries who elect *COBRA* continuation coverage must pay for *COBRA* continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of *COBRA* continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's *COBRA* continuation coverage as of the first day of any period for which timely payment is not made.

Payment for *COBRA* continuation coverage in monthly installments. The Plan is also permitted to allow for payment at other intervals.

Timely Payment for *COBRA* continuation coverage. Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered *Plan Participants* or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the *Employer* and the entity that provides Plan benefits on the *Employer*'s behalf, the *Employer* is allowed until that later date to pay for coverage of similarly situated non-*COBRA* beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of *COBRA* continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of *COBRA* continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a *Reasonable* period of time for payment of the deficiency to be made. A "*Reasonable* period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Questions.
If a *Plan Participant* has questions about *COBRA* continuation coverage, they should contact the *COBRA* Administrator or may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the *Plan Administrator* informed of address changes.
In order to protect a *Plan Participant's* family's rights, a *Plan Participant* should keep the *Plan Administrator* informed of any changes in the addresses of family members. The *Plan Participant* should also keep a copy, for their records, of any notices they send to the *Plan Administrator*.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

Excess Insurance

If at the time of *Injury*, *Sickness*, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

a) Any primary payer besides the Plan;
b) Any first party insurance through medical payment coverage, personal *Injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance Company or guarantor of a third party;
d) Worker's compensation or other liability insurance Company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses

"*Allowable Expenses*" shall mean the *Usual, Reasonable and Customary* charge for any *Medically Necessary*, *Reasonable*, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section entitled Application to Benefit Determinations herein, this Plan's *Allowable Expenses* shall in no event exceed the Other Plan's *Allowable Expenses*. When some Other Plan provides benefits in the form of services rather than cash payments, the *Reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made.

"Claim Determination Period"

"*Claim Determination Period*" shall mean each *Calendar Year*.

Effect on Benefits

When, in accordance with the order of benefit determination rules, this Plan is a secondary plan the benefits of this Plan may be reduced. The benefits of this Plan will be reduced when the sum of the following exceeds the *Allowable Expenses* in the *Calendar Year*:

1. The benefits that would be payable for the *Allowable Expenses* under this Plan in the absence of this COB provision; and

2. The benefits that would be payable for the *Allowed Expenses* under other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made.

Under this provision, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those *Allowable Expenses*.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Application to Benefit Determinations

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the *Plan Participant* who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan or plans will not exceed 100% of *Allowable Expenses*. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal *Injury* protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the *Primary Plan*;

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;

3. If the person for whom claim is made is a dependent *Child* covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the *Child* has not remarried, the benefits of a plan which covers the *Child* as a dependent of the parent with custody will be determined before the benefits of a plan which covers the *Child* as a dependent of the parent without custody; or

b. When the parents are divorced and the parent with custody of the *Child* has remarried, the benefits of a plan which covers the *Child* as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that *Child* as a dependent of the stepparent, and the benefits of a plan which covers that *Child* as a dependent of the stepparent will be determined before the benefits of a plan which covers that *Child* as a dependent of the parent without custody.
c. If both parents have the same birthday, then rule 5 applies.

Also, if the specific terms of a court decree state that the parents have joint custody of the *Child* and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the *Child* but gives physical custody of the *Child* to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent *Child* shall be determined according to rule 4.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the *Child*'s health care expenses, the benefits of the plan which covers the *Child* as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the *Child* as a dependent *Child*; and

4. If a Dependent, as defined by the Plan, has other coverage, then the other coverage shall be primary and this coverage will be secondary.

5. The benefits of a Plan which covers a person as a *Plan Participant* who is neither laid off nor retired or as that *Plan Participant*'s Dependent are determined before those of a Plan which covers that person as a laid off or retired *Plan Participant* or as that *Plan Participant*'s or Retiree's Dependent. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule 3 is ignored.

   If a Dependent is a *Medicare* beneficiary and if, under the Social Security Act of 1965 as amended, *Medicare* is secondary to the Plan covering the person as a Dependent of an active *Plan Participant*, the federal *Medicare* regulations shall supersede this rule 3.

6. If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

   a. First, the benefits of the plan covering the person as a *Plan Participant* or as a Dependent of a *Plan Participant*; and
   b. Second, the benefits under the continuation coverage.

   If the Other Plan contains no provision for coordination of benefits, then the Other Plan pays primary and this Plan pays secondary.

7. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance Company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

The Plan has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent.

2. To require that the claimant provide the Plan with information on such other plans so that this provision may be implemented.

3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the *Plan Administrator*'s opinion, to satisfy the terms of this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan, rather than the amount payable in the absence of this provision.

Right of Recovery

In accordance with the section entitled Recovery of Payments, whenever payments have been made by this Plan with respect to *Allowable Expenses* in a total amount, at any time, in excess of the *Maximum Amount* of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such *Allowable Expenses*, and any future benefits payable to the *Plan Participant* or his or her Dependents.

Coordination of Benefits with *Medicare*

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

Primary for Persons Over 65

This Plan is primary if you are a current *Employee* of the *County* and are age 65 and older, even if You or your Dependent is eligible for *Medicare*.

Primary for Disabled Persons Under Age 65
This Plan is primary if you are a current *Employee* of the *County* and you or your Dependent is under age 65, and eligible for *Medicare* as a disabled beneficiary (other than as an end Stage Renal Disease (ESRD) beneficiary, as provided below).

ESRD Beneficiaries
The Plan is primary for the first 30 months of a *Plan Participant*'s ESRD-based *Medicare* eligibility or entitlement.

Secondary in All Other Cases
This Plan is secondary to *Medicare* in all other cases, including when the *Plan Participant* is eligible for *Medicare* benefits, but not enrolled.

SUBROGATION, REIMBURSEMENT, AND/OR THIRD PARTY RESPONSIBILITY

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *Injury*, *Sickness*, disease or disability is caused in whole or in part by, or results from the acts or omissions of *Plan Participant*s, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "*Plan Participant*(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

2. *Plan Participant*(s), his or her attorney, and/or *Legal Guardian* of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the *Plan Participant*(s) agrees the Plan shall have an equitable lien on any funds received by the *Plan Participant*(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *Plan Participant*(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a *Plan Participant*(s) settles, recovers, or is reimbursed by any Coverage, the *Plan Participant*(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the *Plan Participant*(s). If the *Plan Participant*(s) fails to reimburse the Plan out of any judgment or settlement received, the *Plan Participant*(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the *Plan Participant*(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. Subrogation

To the extent of any payments the Plan makes or may be obliged to make for a claim ("Claim"), the Plan shall be subrogated to all rights of recovery of a *Plan Participant*, his or her parent(s) and dependent(s) or a representative or guardian or trustee of the *Plan Participant*, parent(s) or dependent(s) (collectively referred to as "Claimant") relating to the incident. The subrogation right applies to any recovery, whether by suit, settlement or otherwise, whether partial or full recovery and regardless whether Claimant is made whole, from any source liable for making a payment relating to the injury, illness or condition to which the Claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self funded protection), no fault protection, personal injury protection, financial responsibility, uninsured or underinsured insurance coverages, as well as medical reimbursement coverage purchased by the Claimant or any responsible party.

1. The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this section 11.13 through any appropriate legal or equitable remedy, including but not limited to the initiation of a collection action under any applicable federal or state law, the imposition

of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

2. As a condition to participating in and receiving benefits under this Plan, the *Plan Participant*(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the *Plan Participant*(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

3. If a *Plan Participant*(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any *Plan Participant*(s) may have against any Coverage and/or party causing the *Sickness* or *Injury* to the extent of such conditional payment by the Plan plus *Reasonable* costs of collection.

4. The Plan may, at its discretion, in its own name or in the name of the *Plan Participant*(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

5. If the *Plan Participant*(s) fails to file a claim or pursue damages against:

    a) The responsible party, its insurer, or any other source on behalf of that party;
    b) Any first party insurance through medical payment coverage, personal *Injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c) Any policy of insurance from any insurance Company or guarantor of a third party;
    d) Worker's compensation or other liability insurance Company; or
    e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

    the *Plan Participant*(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the *Plan Participant*(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The *Plan Participant*(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the *Plan Participant*(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the *Plan Participant*(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the *Plan Participant*(s), whether under the doctrines of causation,

comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the *Plan Participant*(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *Sickness*, *Injury*, disease or disability.

D. Excess Insurance

If at the time of *Injury*, *Sickness*, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

a. the responsible party, its insurer, or any other source on behalf of that party;
b. any first party insurance through medical payment coverage, personal *Injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. any policy of insurance from any insurance Company or guarantor of a third party;
d. worker's compensation or other liability insurance Company or
e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

E. Separation of Funds

Benefits paid by the Plan, funds recovered by the *Plan Participant(s)*, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the *Plan Participant(s)*, such that the death of the *Plan Participant(s)*, or filing of bankruptcy by the *Plan Participant(s)*, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. Wrongful Death

In the event that the *Plan Participant*(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the *Plan Participant(s)*' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b. to provide the Plan with pertinent information regarding the *Sickness*, disease, disability, or *Injury*, including accident reports, settlement information and any other requested additional information;
c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
f. to not settle or release, without the prior consent of the Plan, any claim to the extent that the *Plan Participant* may have against any responsible party or Coverage.

2. If the *Plan Participant(s)* and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said *Injury* or condition, out of any proceeds, judgment or settlement received, the *Plan Participant(s)* will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the *Plan Participant(s).*

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the *Plan Participant(s)*' cooperation or adherence to these terms.

H. Offset

Failure by the *Plan Participant(s)* and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the *Plan Participant(s)* may be withheld until the *Plan Participant(s)* satisfies his or her obligation.

I. Attorney's Fees

The Plan specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the Plan shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Plan has agreed in writing to pay such fees or costs. The Plan specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the Plan shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Plan has agreed in writing to pay such fees or costs.

J. Minor Status

1. In the event the *Plan Participant(s)* is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

K. Language Interpretation

The *Plan Administrator* retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The *Plan Administrator* may amend the Plan at any time without notice.

L. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

DEFINITIONS

ACCIDENTAL INJURY
A condition which is the result of bodily *Injury* caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences. This incident must be a sufficient departure from the claimant's normal and ordinary lifestyle or routine. The condition must be an instantaneous one, rather than one which continues, progresses or develops.

ACTIVELY AT WORK
An *Employee* is considered to be *Actively at Work* when performing, in the customary manner, all of the regular duties of their occupation with the *County*. An *Employee* shall be deemed *Actively at Work* on each day of a regular paid vacation; on a regular non-working day, provided they were *Actively at Work* on the last preceding regular working day; or as otherwise noted in the Eligibility section.

ADVERSE BENEFIT DETERMINATION
Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

ALLOWABLE EXPENSES
Any *Medically Necessary, Usual, Reasonable & Customary* expense, *Incurred* while the *Plan Participant* is eligible for benefits under this Plan.

AMBULATORY SURGICAL CENTER
An institution or facility, either free-standing or as part of a *Hospital*, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a *Physician* for the practice of medicine or Dentistry or for the primary purpose of performing terminations of *Pregnancy* shall not be considered to be an *Ambulatory Surgical Center*.

AMENDMENT
A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the *Plan Administrator*.

ASSIGNMENT OF BENEFITS
An arrangement whereby the *Plan Participant* assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a *Plan Participant*, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an *"Assignment of Benefits"* as consideration in full for services, supplies, and/or treatment rendered.

BENEFIT PERCENTAGE
That portion of *Eligible Expenses* to be paid by the Plan in accordance with the coverage provisions as

stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual *Deductible* which are to be paid by the *Plan Participant*.

BENEFIT PERIOD
A time period of one *Calendar Year*. Such *Benefit Period* will terminate on the earliest of the following dates:

1. The last day of the one-year period so established;
2. The day the *Maximum Benefit* applicable to the *Plan Participant* becomes payable.

BIRTHING CENTER
Any free-standing health facility, place, professional office or institution which is not a *Hospital* or in a *Hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the law pertaining to Birth Centers in the jurisdiction where the facility is located.

The *Birthing Center* must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a *Physician* and either a *Registered Nurse* (*R.N.*) or a licensed nurse-midwife; and have a written agreement with a *Hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post- delivery *Confinement*.

CALENDAR YEAR
A period of time commencing on January 1 and ending on December 31 of the same given year.

CERTIFIED COUNSELOR
An individual qualified by education, training, and experience to provide counseling in relation to emotional disorders, psychiatric conditions, or *Substance Abuse*.

CHELATION THERAPY
The technique of introducing a substance into the circulatory system to remove minerals from the body. Often used to treat poisoning by heavy metals like iron, lead and arsenic. Used experimentally to attempt to reduce arterial plaque.

CHILD
The term *"Child"* or *"Children"* includes:
f) An eligible *Plan Participant*'s natural *Child*;
g) An eligible *Plan Participant*'s adopted *Child* (from the date of placement);
h) An eligible *Plan Participant*'s stepchild;
i) An eligible *Plan Participant*'s grandchild until the *Dependent Child's* parent is age 18;
j) Any other *Child* for whom the eligible *Plan Participant* has legal guardianship or for a *Child* for whom the eligible *Plan Participant* had noted legal guardianship on the *Child's* 18th birthday (proof is required).

An "adopted *Child* (from the date of placement)" refers to a *Child* whom the eligible *Plan Participant* has adopted or intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 on the date of such placement for adoption. The term placement means the assumption and retention by such eligible *Plan Participant* of a legal obligation for total or partial support of the *Child* in anticipation of adoption of the *Child*. The *Child* must be available for adoption and the legal process must have commenced.

CHIROPRACTOR TREATMENT
Services performed by a person trained and licensed to practice chiropractic medicine, provided those

services are for the remedy of diseases or conditions which the chiropractor is licensed to treat.

CHIP
CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA
CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

CLAIMS ADMINISTRATOR
The person or firm employed by the *Employer* to provide consulting services to the *Employer* in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

CLEAN CLAIM
A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A *Clean Claim* does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

CLOSE RELATIVE
The spouse, parent, brother, sister, *Child*, or in-law of the *Plan Participant*.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE
Figure shown as a percentage in the Schedule of Benefits used to compute the amount of benefit payable when the Plan states that a percentage is payable. A shared liability between the plan and *Plan Participant* for a covered service.

CONFINEMENT
A continuous stay in the *Hospital*(s) or extended care facility(ies) or combination thereof, due to a *Sickness* or *Injury* diagnosed by a *Physician*.

CONVALESCENT PERIOD
A period of time commencing with the date of *Confinement* by a *Plan Participant* in a Skilled Nursing or Extended Care Facility. A *Convalescent Period* will terminate when the *Plan Participant* has been free of *Confinement* in any and all institutions providing *Hospital* or nursing care for a period of thirty (30) consecutive days. A new *Convalescent Period* shall not commence until a previous *Convalescent Period* has terminated.

CO-PAYMENT
An amount of money that is paid each time a particular service is used.

COSMETIC PROCEDURE
Any procedure performed primarily:

1. to improve physical appearance; or
2. to treat a *Mental Disorder* through a change in bodily form; or
3. to change or restore bodily form without correcting or materially improving a bodily function.

COUNTY
Refers to Walworth County, State of Wisconsin

COVERED MEDICAL EXPENSES
Services and supplies which are not specifically excluded from coverage under this Plan and are *Medically Necessary* to treat *Injury* or *Sickness* unless this Plan specifically states otherwise.

CREDITABLE COVERAGE
Creditable Coverage includes most health coverage, such as coverage under a group health plan (including *COBRA* continuation coverage), HMO membership, an individual health insurance policy, Medicaid or *Medicare*.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

CUSTODIAL CARE
That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a *Plan Participant*, whether or not *Totally Disabled*, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE
A specified dollar amount of covered expenses which must be *Incurred* during a *Benefit Period* before any other covered expenses can be considered for payment.

DEFRA
The Deficit Reduction Act of 1984, as amended.

DENTIST
An individual who is duly licensed to practice Dentistry or oral *surgery* in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a *Physician* will be considered to be a *Dentist* when he or she performs any of the dental services described herein and is operating within the scope of his license.

DEPENDENT COVERAGE
Eligibility under the terms of the Plan for benefits payable as a consequence of *Eligible Expenses Incurred* for a *Sickness* or *Injury* of a Dependent.

DURABLE MEDICAL EQUIPMENT
Equipment prescribed by the attending *Physician* which meets all of the following requirements: 1) it is *Medically Necessary*; 2) it can withstand repeated use; 3) it is not disposable, unless provided in connection with direct physician care or covered home care; 4) it is not useful in the absence of a *Sickness* or *Injury*; 5) it would have been covered if provided in a *Hospital*; and 6) it is appropriate for use in the home.

ELIGIBLE EXPENSE
Any *Medically Necessary* treatment, service, or supply that is not specifically excluded from coverage elsewhere in this Plan.

ELIGIBLE PROVIDER
Eligible Providers shall include the following legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered *Eligible Expenses* under the Plan:
- Acupuncturist
- *Ambulatory Surgical Center*
- Audiologist (MS)
- *Birthing Center*
- *Certified Counselor*
- Certified *Registered Nurse* Anesthetist
- Chiropractor
- Clinic
- *Dentist*
- Dialysis Center
- Home Health Agency
- *Hospice*
- *Hospital*
- Laboratory
- *Licensed Practical Nurse*
- Medical Supply Purveyor
- Midwife
- Nurse Practitioner
- *Occupational Therapist*
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath
- *Outpatient Psychiatric Treatment Facility*
- *Outpatient Substance Abuse Treatment Facility*
- Pharmacy/Pharmacist
- *Physical Therapist*
- *Physician* (M.D.)
- *Physician*'s Assistant
- Podiatrist
- Professional ambulance service
- Psychiatrist
- *Psychologist*
- Registered Dietitian
- *Registered Nurse*
- *Skilled Nursing Facility*
- *Social Worker*
- *Speech Therapist*

"*Eligible Provider*" shall not include the *Plan Participant* or any *Close Relative* of the *Plan Participant*.

EMERGENCY
An acute, sudden onset of a *Sickness* or bodily injury which is life threatening or will significantly worsen without immediate medical or surgical treatment.

EMERGENCY MEDICAL CONDITION
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn *Child*) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES
Emergency Services means, with respect to an *Emergency Medical Condition*:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the *Emergency* department of a *Hospital*, including ancillary services routinely available to the *Emergency* department to evaluate such *Emergency Medical Condition*; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *Hospital*, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

EMPLOYEE
Employee means you, as an *Employee*, when you are regularly employed and paid a salary or earnings and are in an active status at your *Employer*'s place of business.

EMPLOYEE COVERAGE
Coverage hereunder providing benefits payable as a consequence of an *Injury* or *Sickness* of an *Employee*.

EMPLOYER
Walworth County

ENROLLMENT DATE
Enrollment Date, within the meaning of *HIPAA*, as defined by the Department of Labor is the first day of coverage. If there is a Waiting Period, it is the first day of the Waiting Period.

ESSENTIAL HEALTH BENEFITS
Essential Health Benefits mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; *Emergency Services*; *Hospitali*zation; maternity and *Newborn* care; mental health and *Substance Abuse* disorder services, including behavioral health treatment; *Prescription Drug*s; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPENSES INCURRED
The fee charged for services provided to you. The date a service is provided is the *Expense Incurred* date.

EXPERIMENTAL
"*Experimental*" and/or "Investigational" ("*Experimental*") shall mean services or treatments that:

1. are not accepted as standard medical treatment for the illness, disease or *injury* being treated by *Physicians* or most practitioners practicing the suitable medical specialty;
2. are the subject of scientific or medical research or study to determine the item or regimen's effectiveness and safety;
3. have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including but not limited to the Federal Department of Health and Human Services, Food and Drug Administration, or any comparable state government agency, and the Federal Health care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
4. are performed subject to the *Plan Participant*'s informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

All phases of clinical trials shall be considered *Experimental*.

FAMILY UNIT
A *Plan Participant* and his eligible Dependents.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
A Federal law, effective August 5, 1993, applying to *Employer*s with fifty (50) or more employees, and applicable State law.

FIDUCIARY
Walworth County, which has the authority to control and manage the operation and administration of this Plan.

FORMULARY
A list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

GENETIC INFORMATION
Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

GINA
GINA means the *Genetic Information* Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and *Employer*s from discriminating on the basis of *Genetic Information*.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE AGENCY
An organization whose main function is to provide home health care services and supplies, is Federally certified as a *Home Health Care Agency*, and is licensed by the state in which it is located, if licensing is required.

HOME HEALTH CARE PLAN
A program for continued care and treatment of the *Plan Participant* established and approved in writing by the *Plan Participant's* attending *Physician*. The attending *Physician* must certify that the proper treatment of the *Sickness* or *Injury* would require continued *Confinement* as a resident *Inpatient* in a *Hospital* or extended care facility in the absence of the services and supplies provided as part of the *Home Health Care Plan*.

HOSPICE
A health care program providing a coordinated set of services rendered at home, in *Outpatient* settings, or in institutional settings for *Plan Participants* suffering from a condition that has a terminal prognosis. A *Hospice* must have an interdisciplinary group of personnel which includes at least one *Physician* and one *Registered Nurse*, and its staff must maintain central clinical records on all patients. A *Hospice* must meet the standards of the National *Hospice* Organization (NHO) and applicable state licensing.

HOSPITAL
An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to an ill or injured person on an *Inpatient* basis at the patient's expense.

2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to *Hospital*s.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of a *Sickness* or an *Injury*.

4. Such treatment is provided for compensation by or under the supervision of *Physician*s, with continuous 24 hour nursing services by *Registered Nurse*s (*R.N.*'s).

5. It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO). The JCAHCO accreditation limitation may be waived at the discretion of the Plan if the only *Hospital* in the immediate area is not JCAHCO approved.

6. It is a provider of services under *Medicare*.

7. It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "*Hospital*" will also include an institution qualified for the treatment of psychiatric problems, *Substance Abuse*, or tuberculosis that does not have surgical facilities and/or is not approved by *Medicare*, provided that such institution satisfies the definition of *Hospital* in all other respects.

HOSPITAL MISCELLANEOUS EXPENSES
The actual charges made by a *Hospital* in its own behalf for services and supplies rendered to the *Plan Participant* which are *Medically Necessary* for the treatment of such *Plan Participant*. *Hospital Miscellaneous Expenses* do not include charges for *Room and Board* or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the *Hospital* or otherwise.

ILLNESS
A bodily disorder, disease, physical *Sickness*, mental infirmity, or functional nervous disorder of a *Plan Participant*. A recurrent *Sickness* will be considered one *Sickness*. Concurrent *Sickness*es will be

considered one *Sickness* unless the concurrent *Sickness*es are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one *Sickness*.

INCURRED
Incurred means that a covered expense is *Incurred* on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are *Incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not *Incurred* upon commencement of the first stage of the procedure or course of treatment.

INJURY
The term "*Injury*" shall mean only accidental bodily *Injury* caused by an external force, occurring while the Plan is in effect. All injuries to one person from one accident shall be considered an "*Injury*."

INPATIENT CARE
Hospital Room and Board and general nursing care for a person confined in a *Hospital* or extended care facility as a bed patient.

INTENSIVE CARE UNIT (ICU)
An area within a *Hospital* which is reserved, equipped, and staffed by the *Hospital* for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

JAW JOINT DISORDERS
Treatment of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

LATE ENROLLEES
An individual who is enrolled for coverage after the initial eligibility date described in the section entitled "Late Enrollment." Note, however, a *Special Enrollee* shall not be considered a *Late Enrollee* hereunder.

LEGAL GUARDIAN
A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor *Child.*

***LICENSED PRACTICAL NURSE* (*L.P.N.*)**
An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LIFETIME
The term "*Lifetime,*" which is used in connection with benefit maximums and limitations, means the period during which the person is covered under this Plan, whether or not coverage is continuous. Under no circumstances does "*Lifetime*" mean during the *Lifetime* of the *Plan Participant.*

MAXIMUM AMOUNT* OR *MAXIMUM ALLOWABLE CHARGE
The benefit payable for a specific coverage item or benefit under the Plan. *Maximum Allowable Charge(s)* will be the lesser of:

- The *Usual, Reasonable and Customary* amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the *Usual, Reasonable and Customary* amount. The Plan has the discretionary authority to decide if a charge is *Usual, Reasonable and Customary* and for a *Medically Necessary* and *Reasonable* service.

The ***Maximum Allowable Charge*** will not include any identifiable billing mistakes including, but not limited to: up-coding, duplicate charges, and charges for services not performed.

MAXIMUM BENEFIT
The maximum amount that may be payable for each *Plan Participant*, for *Expense Incurred*. The applicable *Maximum Benefit* is shown on the Schedule of Benefits. No further benefits are payable once the maximum is reached.

MEDICAL CARE FACILITY
A *Hospital*, or a facility that treats one or more specific ailments or any type of Skilled Nursing or Extended Care Facility.

MEDICALLY NECESSARY/DENTALLY NECESSARY
The service a patient receives which is recommended by a *Physician* and is required to treat the symptoms of a certain *Injury* or *Sickness*. Although the service may be prescribed by *Physician*, it does not mean the service is *Medically Necessary*. The care or treatment 1) must be consistent with the diagnosis and prescribed course of treatment for the *Plan Participant's* condition; 2) must be required for reasons other than the convenience of the *Plan Participant* or the attending *Physician*; 3) is generally accepted as an appropriate form of care for the condition being treated; and 4) is likely to result in physical improvement of the patient's condition which is unlikely to ever occur if the treatment is not administered.

MEDICARE
The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

MENTAL DISORDERS
A condition which is classified as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder of any kind. To be considered a Mental Disorder under this Plan the condition must be defined as such in the "International Classification of Disease Adopted" under 9 Section V – *Mental Disorders*.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 ("MHPAEA")
"*Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")"* means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost

sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use order benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

MISCELLANEOUS HOSPITAL SERVICES
The actual charges made by a *Hospital*, other than *Room and Board*, on its own behalf for services and supplies rendered to the *Plan Participant*, on an *Inpatient* or *Outpatient* basis, which are *Medically Necessary* for the treatment of such *Plan Participant*. This includes *Hospital* admission kits, but all other personal or convenience items are excluded.

MORBID OBESITY
A diagnosed condition in which the body weight exceeds the medically recommended weight for the person of the same height, age and mobility as the *Plan Participant*, per the guidelines set forth in the insurance industry.

NEGOTIATED FEE
This is the amount agreed upon between the provider and the Preferred Provider Organization, regarding the fee the provider should be reimbursed. As part of participating in the Preferred Provider Network the provider has agreed to reduce their fees for Network participants.

NEWBORN
An infant from the date of birth until the mother is discharged from the *Hospital*.

NO-FAULT AUTO INSURANCE
The basic reparations provision of the law providing for payments without determining fault in connection with automobile accidents.

NON-PARTICIPATING PHARMACY
A Pharmacy which has not entered into an agreement with the drug *Plan Administrator* to participate as part of the Pharmacy network.

OCCUPATIONAL THERAPIST
A licensed practitioner who treats, primarily, the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

OCCUPATIONAL THERAPY
The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a

variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life.

OUTPATIENT
The classification of a *Plan Participant* when that *Plan Participant* receives medical care, treatment, services, or supplies at a clinic, a *Physician*'s office, a *Hospital* if not a registered bed patient at that *Hospital*, an *Outpatient* psychiatric facility, or an *Outpatient Substance Abuse Treatment Facility*.

OUTPATIENT PSYCHIATRIC TREATMENT FACILITY
An administratively distinct governmental, public, private or independent unit or part of such unit that provides *Outpatient* mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY
An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or *Substance Abuse*; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services that may be required; is at all times supervised by a staff of *Physician*s; prepares and maintains a written plan of treatment for each patient, based on the patient's medical, psychological, and social needs and supervised by a *Physician*; and meets licensing standards.

OUTPATIENT SURGERY
Outpatient Surgery includes, but is not limited to, the following types of procedures performed in a *Hospital* or surgi-center:

1. Operative or cutting procedures for the treatment of a *Sickness* or *Injury*;
2. The treatment of fractures and dislocations; or
3. Endoscopic or diagnostic procedures such as biopsies, cystoscopy, bronchoscopy, and angiocardiography.

PHYSICAL THERAPIST
A licensed practitioner who treats patients by means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises. Where there is no licensure law, the *Physical Therapist* must be certified by the appropriate professional body.

PHYSICAL THERAPY
Treatment by the means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises.

PHYSICAN
A legally-licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical *Psychologist* to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A *Physician* shall not include the *Plan Participant* or any *Close Relative* of the *Plan Participant*.

PLAN ADMINISTRATOR
The *Employer* which is responsible for the management of the Plan who will have the authority to control and manage the operation and administration of the Plan. The *Plan Administrator* (or similar decision making body) has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation, or operation of the Plan, including, but not limited to, eligibility under the Plan, the terms and provisions of the Plan, including any alleged vague or ambiguous term or provision, and to determine payment of benefits or claims under the

Plan and any and all other matters arising under the Plan.

The *Plan Administrator* may employ persons or firms to process claims and perform other Plan-connected services. The *Plan Administrator* is the named *Plan Administrator* within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended. The *Plan Administrator* has the final and discretionary authority to determine the *Usual, Reasonable* & *Customary* amount, in consultation with the *Claims Administrator* or vendor firms that it may offer through the administrative services package to assist in this determination.

PLAN PARTICIPANT
Any individual who is employed by Walworth County in a qualifying position, a County Board Supervisor, elected officers, or a qualifying retiree of Walworth County, subject to *County* Personnel Policy and/or any applicable collective bargaining agreement or *County* Ordinance, and any eligible Dependents meeting the eligibility requirements for coverage as specified in this Plan and properly enrolled in this Plan.

PLAN YEAR
The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first *Plan Year* which is a short *Plan Year*. This Plan recognizes *Plan Year* as January 1st to December 31st.

PREGNANCY
That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRESCRIPTION DRUG
Any of the following: a Food and Drug Administration-approved drug or medicine which, under Federal Law, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *Physician*. Such drugs must be *Medically Necessary* in the treatment of a *Sickness* or *Injury*.

In regards to drugs and drug therapies newly approved by the U.S. Food and Drug Administration (FDA) and available to the consumer market after the Summary Plan Descriptions have been distributed, the Plan reserves the right to:

- Extend coverage to medications that have recently met the FDA guidelines;
- Assign a unique *Co-payment* or *Coinsurance* to new drugs entering the market;
- Limit quantities of new lifestyle-type drugs entering the market; and
- Add drugs to the exclusion list if the FDA has issued a warning or a recall, voluntary or otherwise, to the consumer market.

*Plan Participant*s will receive notices regarding any Plan modifications regarding drugs or therapies at such time that they present a prescription for drugs or drug therapies impacted by modifications to the Plan. Participating pharmacies are charged to communicate any updates or changes to the Plan pharmacy program which impact a *Plan Participant*.

PREVENTIVE CARE
Medical treatment, services or supplies rendered solely for the purpose of maintaining health and not for the treatment of an *Injury* or *Sickness*. When a claim is submitted, the *Physician*'s office must code the

claim to indicate *Preventive Care* or this Plan will consider the claim as treatment of an *Injury* or *Sickness*.

PRIMARY PLAN
A plan whose allowable benefits are not reduced by those of another plan.

PRIOR TO EFFECTIVE DATE* OR *AFTER TERMINATION DATE
Prior to Effective Date or *After Termination Date* are dates occurring before a *Plan Participant* gains eligibility from the Plan, or dates occurring after a *Plan Participant* loses eligibility from the Plan, as well as charges *Incurred* prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

PRONOUNS
Any references to " *Plan Participant*", "He", or "Himself" means the eligible *Plan Participant* and Covered Dependents.

PSYCHIATRIC CARE
The term "*Psychiatric Care*," also known as psychoanalytic care, means treatment for a mental *Sickness* or disorder, a functional nervous disorder, alcoholism, or drug addiction. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic depression.

PSYCHOLOGIST
A registered clinical *Psychologist*. A *Psychologist* who specializes in the evaluation and treatment of mental *Sickness* who is registered with the appropriate state registering body or, in a state where statutory licensure exists, holds a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, meets the following qualifications: Has a doctoral degree from an accredited university, college, or professional school and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or, holds a graduate degree from an accredited university or college and has not less than six years as a *Psychologist* with at least two years of supervised experience in health services.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
In order to meet the definition of a *Qualified Medical Child Support Order (QMCSO)* or court order for dependent support must contain all of the following information:

1. The *Plan Participant's* name and last known address.
2. The Dependent's full name and address.
3. A *Reasonable* description of the coverage to be provided or the manner in which coverage will be established, i.e. through the *Employer*.
4. The period for which coverage must be provided.
5. The order or decree must specifically name the *County* as a source of coverage.

A National Medical Support notice will also meet the definition of a *QMCSO*.

Should any *Plan Participant* or beneficiary need a copy of the procedures that govern *Qualified Medical Child Support Order (QMCSO)* determinations, they will be provided by the *Plan Administrator*, free of charge, upon request.

REASONABLE
"*Reasonable*" and/or "*Reasonable*ness" means in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of *Illness* or *Injury* not caused by the treating Provider. Determination that fee(s) or services are *Reasonable* will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of *Injury* or *Illness* necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be *Reasonable*, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not *Reasonable.* The *Plan Administrator* retains discretionary authority to determine whether service(s) and/or fee(s) are *Reasonable* based upon information presented to the *Plan Administrator* after consultation with the *Claims Administrator* and contract vendors for assistance. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not *Reasonable*.

Charge(s) and/or services are not considered to be *Reasonable*, and as such are not eligible for payment (exceed the *Maximum Allowable Charge*), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not *Reasonable* and therefore not eligible for payment by the Plan.

***REGISTERED NURSE* (*R.N.*)**
An individual who has received specialized nursing training and is authorized to use the designation of "*R.N.*," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

REGULAR BASIS
A basis whereby an *Employee* is regularly at work as shown in the section titled Eligibility for Coverage. Such work may occur either at the usual place of business of the *Employer* or at a location to which the business of the *Employer* requires the *Employee* to travel and for which he or she receives regular earnings from the *County*.

REVIEW ORGANIZATION
The organization contracting with the *County* to perform cost containment services.

ROOM AND BOARD
All charges for accommodations which are made by a *Hospital*, *Hospice*, or extended care facility as a condition of occupancy. Such charges do not include the professional services of *Physician*s nor intensive nursing care (by whatever name called).

SEMI-PRIVATE
A class of accommodations in a *Hospital* or extended care facility in which at least two patient beds are available per room.

SICKNESS
A person's *Illness*, disease or *Pregnancy* (including complications).

SIGNIFICANT BREAK IN COVERAGE
A period of 63 (or more) consecutive days without *Creditable Coverage*. A Waiting Period shall not be taken into account for purposes of determining whether a *Significant Break in Coverage* has occurred.

With respect to a Qualified *Plan Participant* who elects *COBRA* Continuation Coverage pursuant to the American Recovery and Reinvestment Act of 2009 and the Department of Defense Appropriations Act, 2010, the following periods shall be disregarded for purposes of determining the 63-day break in coverage period:

1. The period beginning on the date of the Qualifying Event; and
2. The period ending with the start of *COBRA* Continuation Coverage.

SKILLED NURSING FACILITY
An institution, or distinct part thereof, operated pursuant to law, and one which meets all of the following conditions:

1. It is licensed to provide and is engaged in providing, on an *Inpatient* basis for persons convalescing from *Injury* or *Sickness*, professional nursing services rendered by a *Registered Nurse* (*R.N.*) or by a *Licensed Practical Nurse* (*L.P.N.*) under the direction of a *Registered Nurse* and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a *Physician* or *Registered Nurse*.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time *Registered Nurse*.
4. Its staff maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of *Mental Disorders*.
7. It is approved and licensed by *Medicare*.

This term shall apply to *Expenses Incurred* in an institution referring to itself as a *Skilled Nursing Facility*, Extended Care Facility, or any such other similar facility.

SOCIAL WORKER
An individual who is licensed to provide services in relation to the treatment of emotional disorders, psychiatric conditions; or *Substance Abuse*.

SPECIAL ENROLLEE
A *Plan Participant* or Dependent who is entitled to and who requests Special Enrollment within 31 days of losing other health coverage or a newly acquired Dependent for whom coverage is requested within 31 days of the marriage, birth, adoption, or placement for adoption.

If the loss of coverage was through a Medicaid or *CHIP* program, the *Plan Participant* or Dependent requests enrollment in this Plan no later than 60-days after the date of exhaustion or cancellation by the Medicaid or *CHIP* program.

SPEECH THERAPIST
An individual who is skilled in the treatment of communication and swallowing disorders due to *Sickness*, *Injury* or birth defect, is a member of the American Speech and Hearing Association, has a Certificate of Clinical Competence, and is licensed in the state in which services are provided.

SPINAL MANIPULATION
Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *Physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

SUBSTANCE ABUSE
Any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders definition is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

    1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of *Child*ren or household);
    2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

SURGERY
The branch of medicine that employs operations in the treatment of disease or injury. *Surgery* can involve cutting, abrading, suturing, or otherwise physically changing body tissues and organ, but also may involve manipulation from outside the body, which may include but not be limited to processes such as setting of a broken bone, skin grafts, blood typing, intubation to support breathing, intravenous administration of fluids and drugs, heart-lung machines, endoscopy, colonoscopy, sigmoidoscopy, and devices that monitor body functions.

TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)
Treatment of *Jaw Joint Disorders* including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, *Physical Therapy* and any appliance that is attached to or rests on the teeth.

THERAPY
Services or supplies used for the treatment of a *Sickness* or *Injury* to promote the recovery of a *Plan*

Participant. *Therapy* services are covered to the extent specified in the Plan.

***TOTAL DISABILITY* (*TOTALLY DISABLED*)**
A physical state of a *Plan Participant* resulting from a *Sickness* or *Injury* which wholly prevents:

1. An *Employee* from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
2. A Dependent from performing the normal activities of a person of like age and sex and in good health.

TRANSITIONAL TREATMENT
In a *Transitional Treatment* program, services are rendered in a less restrictive manner than *Inpatient* services but in a more intensive manner than are *Outpatient* services and can represent the following:

- A non-residential program which provides case management, counseling, medical care and psychotherapy on a regular basis for a scheduled part of a day and a scheduled number of days per week. This program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial *Hospital* services, if required by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four (4) hours, a day.
- A residential treatment program in a qualified facility certified by the Department of Health and Family Services and is designed to provide individualized, active treatment within an intensively staffed residential setting. Residential Treatment Facilities are less restrictive and less intensively staffed than *Hospital*-based programs, but more intensively staffed and provide a wider range of services than community residences.

URGENT CARE CLINIC
A free-standing facility or a designated Urgent Care location within a facility which is engaged primarily in providing minor *Emergency* and episodic medical care to a *Plan Participant*. A board-certified *Physician*, a *Registered Nurse*, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facility must include x-ray and laboratory equipment and a life support system. These types of facilities bill on HCFA or CMS 1500 forms with Place of Service 20.

URGENT CARE ROOM
Hospital billed room that is used for treating conditions of lesser severity then would be needed with an *Emergency* Room. *Hospital*s bill *Urgent Care Room*s with Revenue Code 456 or 516 on a *Hospital* bill (UB-92 or UB-04 for example).

USUAL, REASONABLE AND CUSTOMARY (U&C)
Covered expenses which are identified by the *Plan Administrator*, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be *Usual, Reasonable and Customary*, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "*Usual*" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals

with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is *Incurred*.

The term "*Customary*" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "*Usual, Reasonable and Customary*" does not necessarily mean the actual charge made nor the specific service or supply furnished to a *Plan Participant* by a Provider of services or supplies, such as a *Physician*, therapist, nurse, *Hospital*, or pharmacist. The *Plan Administrator* will determine what the *Usual, Reasonable and Customary* charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is *Usual, Reasonable and Customary*.

Usual, Reasonable and Customary charges may, at the *Plan Administrator*'s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

WELL-CARE

The term "*Well-Care*" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and not for the treatment of a *Sickness* or *Injury*. This includes pediatric preventive services, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the *Child* as defined by standards of Child Health Care issued by the American Academy of Pediatrics.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by *Plan Participants* to obtain payment of health benefits under this Plan.

Health Claims
All claims and questions regarding health claims should be directed to the *Claims Administrator*. The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the *Plan Administrator* decides in its discretion that the *Plan Participant* is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the *Claims Administrator*; provided, however, that the *Claims Administrator* is not a *Fiduciary* of the Plan and does not have the authority to make decisions involving the use of discretion.

Each *Plan Participant* claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were *Incurred* or that the benefit is covered under the Plan. If the *Plan Administrator* in its sole discretion shall determine that the *Plan Participant* has not *Incurred* a covered expense or that the benefit is not covered under the Plan, or if the *Plan Participant* shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a *Clean Claim* must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

Filing a Clean Claim. A Provider submits a *Clean Claim* by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The *Plan Administrator* may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a *Clean Claim* if the *Plan Participant* has failed to submit required forms or additional information to the Plan as well.

A *Plan Participant* has the right to request a review of an *Adverse Benefit Determination*. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final *Adverse Benefit Determination*. If the *Plan Participant* receives notice of a final *Adverse Benefit Determination*, or if the Plan does not follow the claims procedures properly, the *Plan Participant* then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a *Plan Participant*, or to a Provider that has accepted an *Assignment of Benefits* as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *Plan Participant* or the *Plan Participant*'s ability to regain maximum function, or, in the opinion of a *Physician* with knowledge of the *Plan Participant*'s medical condition, would subject the *Plan Participant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   If the Plan does not require the *Plan Participant* to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The *Plan Participant* simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or
   b. The *Plan Participant* requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the *Plan Participant* to obtain approval of a medical service prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment. The *Plan Participant* simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service health claims must be filed with the *Claims Administrator* within 12 months of the date charges for the service were *Incurred*. Benefits are based upon the Plan's provisions at the time the charges were *Incurred*. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the *Claims Administrator* in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The *Claims Administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *Claims Administrator* within 45 days from receipt by the *Plan Participant* of the

request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The *Claims Administrator*, as directed by the *Plan Administrator* shall notify the *Plan Participant*, in accordance with the provisions set forth below, of any *Adverse Benefit Determination* (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:
  - If the *Plan Participant* has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If the *Plan Participant* has not provided all of the information needed to process the claim, then the *Plan Participant* will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
  - The *Plan Participant* will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded the *Plan Participant* to provide the information.
  - If there is an *Adverse Benefit Determination*, a request for an expedited appeal may be submitted orally or in writing by the *Plan Participant*. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the *Plan Participant* by telephone, facsimile, or other similarly expeditious method. Alternatively, the *Plan Participant* may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
  - If the *Plan Participant* has provided all of the information needed to process the claim, in a *Reasonable* period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the *Plan Participant* has not provided all of the information needed to process the claim, then the *Plan Participant* will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The *Plan Participant* will be notified of a determination of benefits in a *Reasonable* period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Claims Administrator*, as directed by the *Plan Administrator* and the *Plan Participant* (if additional information was requested during the extension period).
- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the *Claims Administrator*, as directed by the *Plan Administrator* is notifying the *Plan Participant* of a reduction or termination of a course

of treatment (other than by Plan *Amendment* or termination), before the end of such period of time or number of treatments. The *Plan Participant* will be notified sufficiently in advance of the reduction or termination to allow the *Plan Participant* to appeal and obtain a determination on review of that *Adverse Benefit Determination* before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan *Amendment* or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

- Request by *Plan Participant* Involving Urgent Care. If the *Claims Administrator*, as directed by the *Plan Administrator* receives a request from a *Plan Participant* to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the *Plan Participant* makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the *Plan Participant* submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

- Request by *Plan Participant* Involving Non-urgent Care. If the *Plan Administrator* receives a request from the *Plan Participant* to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Request by *Plan Participant* Involving Rescission. With respect to rescissions, the following timetable applies:

  - Notification to *Plan Participant* 30 days

  - Notification of *Adverse Benefit Determination* on appeal 30 days

- Post-service Claims:

  - If the *Plan Participant* has provided all of the information needed to process the claim, in a *Reasonable* period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the *Plan Participant* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *Plan Participant* will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the *Plan Participant* will be notified of the determination by a date agreed to by the *Plan Administrator* and the *Plan Participant*.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the *Claims Administrator*, as directed by the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the *Plan Participant*, prior to the expiration of the initial 15-day processing period, of the

circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the *Claims Administrator*, as directed by the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the *Plan Participant*, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an *Adverse Benefit Determination*

The *Claims Administrator*, as directed by the *Plan Administrator* shall provide a *Plan Participant* with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the *Plan Participant* to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the *Plan Participant* to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal following an *Adverse Benefit Determination* on final review;

- A statement that the *Plan Participant* is entitled to receive, upon request and free of charge, *Reasonable* access to, and copies of, all documents, records and other information relevant to the *Plan Participant*'s claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the *Plan Participant*, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is *Medically Necessary* or *Experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *Plan Participant*'s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the *Plan Participant*, free of charge, upon request;
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of *Adverse Benefit Determination*s

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the *Plan Participant* believes the claim has been denied wrongly, the *Plan Participant* may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a *Plan Participant* with a *Reasonable* opportunity for a full and fair review of a claim and *Adverse Benefit Determination*. More specifically, the Plan provides:

- *Plan Participants* at least 180 days following receipt of a notification of an initial *Adverse Benefit Determination* within which to appeal the determination;

- *Plan Participants* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- *Plan Participants* the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous *Adverse Benefit Determination* and that is conducted by an appropriate named *Fiduciary* of the Plan, who shall be neither the individual who made the *Adverse Benefit Determination* that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the *Plan Participant* relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any *Adverse Benefit Determination* that is based in whole or in part upon a medical judgment, the Plan *Fiduciary* shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the *Adverse Benefit Determination* that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a *Plan Participant* will be provided, free of charge: (a) *Reasonable* access to, and copies of, all documents, records, and other information relevant to the *Plan Participant*'s claim in possession of the *Plan Administrator* or *Claims Administrator*; ; (b) information regarding any

voluntary appeals procedures offered by the Plan; (c) information regarding the *Plan Participant*'s right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *Plan Participant*'s medical circumstances; and

- That a *Plan Participant* will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal *Adverse Benefit Determination* is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the *Plan Participant* to respond to such new evidence or rationale.

Requirements for Appeal
The *Plan Participant* must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an *Adverse Benefit Determination*. For pre-service urgent care claims, if the *Plan Participant* chooses to orally appeal, the *Plan Participant* may telephone:

Walworth County Human Resources/Benefits
100 West Walworth Street
P.O. Box 1001
Elkhorn, WI 53121
Phone: (262) 741-7950
Fax: (262) 741-7963

Auxiant
2450 Rimrock Road
Suite 301
Madison, WI 53713
Phone: (800) 279-6772
Fax: (608) 273-4554
Email/Website: www.auxiant.com

To file an appeal in writing, the *Plan Participant*'s appeal must be addressed as follows and mailed or faxed as follows:

Walworth County Human Resources/Benefits
100 West Walworth Street
P.O. Box 1001
Elkhorn, WI 53121
Phone: (262) 741-7950
Fax: (262) 741-7963

Auxiant
2450 Rimrock Road
Suite 301
Madison, WI 53713
Phone: (800) 279-6772
Fax: (608) 273-4554
Email/Website: www.auxiant.com

It shall be the responsibility of the *Plan Participant* to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the *Employee*/*Plan Participant;*
- The *Employee/Plan Participant's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *Plan Participant* will lose the right to raise factual arguments and theories which support this claim if the *Plan Participant* fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *Plan Participant* has which indicates that the *Plan Participant* is entitled to benefits under the Plan.

If the *Plan Participant* provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The *Claims Administrator*, as directed by the *Plan Administrator* shall notify the *Plan Participant* of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of *Adverse Benefit Determination* on Review
The *Claims Administrator*, as directed by the *Plan Administrator* shall provide a *Plan Participant* with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's *Adverse Benefit Determination* on review, setting forth:

- Information sufficient to allow the *Plan Participant* to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the *Plan Participant* to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal following an *Adverse Benefit Determination* on final review;

- A statement that the *Plan Participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan Participant*'s claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the *Plan Participant*, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is *Medically Necessary* or *Experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *Plan Participant*'s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the *Plan Participant*, free of charge, upon request; and

- 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."

Furnishing Documents in the Event of an Adverse Determination
In the case of an *Adverse Benefit Determination* on review, the *Claims Administrator*, as directed by the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of *Adverse Benefit Determination* on Review" as appropriate.

Decision on Review to be Final
If, for any reason, the *Plan Participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *Plan Participant* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named *Fiduciary* of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a *Plan Participant* or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The external review process applies only to:
   (a) An *Adverse Benefit Determination* (including a final internal *Adverse Benefit Determination*) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is *Experimental* or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review
Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an *Adverse Benefit Determination* or final internal *Adverse Benefit Determination*. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The *Adverse Benefit Determination* or the final *Adverse Benefit Determination* does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent *Review Organization.* The Plan will assign an independent *Review Organization* (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the *Adverse Benefit Determination* or final internal *Adverse Benefit Determination*, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A final internal *Adverse Benefit Determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received *Emergency Services*, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent *Review Organization.* Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the

requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* or final internal *Adverse Benefit Determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Appointment of Authorized Representative

A *Plan Participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An *Assignment of Benefits* by a *Plan Participant* to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the *Plan Participant* must complete a form which can be obtained from the *Plan Administrator* or the *Claims Administrator*. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the *Plan Participant*'s medical condition to act as the *Plan Participant*'s authorized representative without completion of this form. In the event a *Plan Participant* designates an authorized representative, all future communications from the Plan will be with the representative, rather than the *Plan Participant*, unless the *Plan Participant* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a *Physician* of its own choosing examine any *Plan Participant* whose condition, *Sickness* or *Injury* is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The *Plan Participant* must comply with this requirement as a necessary condition to coverage.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased *Plan Participant* whose condition, *Sickness*, or *Injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered *Plan Participant* whose *Sickness* or *Injury*, or whose covered Dependent's *Sickness* or *Injury*, is the basis of a claim. In the event of the death or incapacity of a covered *Plan Participant* and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such *Plan Participant*.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a *Plan Participant* to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the *Plan Participant*, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *Plan Participant* and the assignee, has been received before the proof of loss is submitted.

No *Plan Participant* shall at any time, either during the time in which he or she is a *Plan Participant* in the Plan, or following his or her termination as a *Plan Participant*, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an *Assignment of Benefits*, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers
Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The *Plan Participant* is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the *Incurred* Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the *Maximum Allowable Charge*. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *Plan Participant* or dependent on whose behalf such payment was made.

A *Plan Participant*, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the Plan for an erroneous

payment and whether such payment shall be reimbursed in a lump sum. When a *Plan Participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *Plan Participant* and to deny or reduce future benefits payable (including payment of future benefits for other injuries or *Illness*es) under the Plan by the amount due as reimbursement to the Plan. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or *Illness*es) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a *Plan Participant*, Provider or other person or entity to enforce the provisions of this section, then that *Plan Participant*, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, *Plan Participant*s and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*Plan Participant*s) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the *Plan Participant*(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a *Plan Participant* fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational *Injury* or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a *Plan Participant* or by any of his Covered Dependents if such payment is made with respect to the *Plan Participant* or any person covered or asserting coverage as a Dependent of the *Plan Participant*.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the *Plan Participant* for any outstanding amount(s).

Medicaid Coverage

A *Plan Participant*'s eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *Plan Participant*. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the *Plan Participant*, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

GENERAL PROVISIONS

Applicable Law

This is a self-funded benefit plan coming within the purview of the laws of the State of Wisconsin. The Plan is funded with *Plan Participant* and/or *Employer* contributions.

Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to *Plan Participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of the laws of the state of Wisconsin applicable to employee welfare plans.

Fraud

The following actions by any *Plan Participant*, or a *Plan Participant*'s knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire *Family Unit* of which the *Plan Participant* is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a *Plan Participant*;
2. Attempting to file a claim for a *Plan Participant* for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. *Plan Participants* are advised not to rely on any provision because of the heading.

No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions

The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the participating *Employer* and the amount to be contributed (if any) by each *Plan Participant*.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other State laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Sponsor shall be free to determine the manner and means of funding the Plan. The amount of the *Plan Participant*'s contribution (if any) will be determined from time to time by the Plan Sponsor.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *Plan Participant* for benefits from this Plan. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action. Any *Plan Participant* claiming benefits under this Plan shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the section entitled Recovery of Payments, whenever payments have been made by this Plan in a total amount, at any time, in excess of the *Maximum Amount* of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the *Plan Participant* or his or her Dependents.

Statements

All statements made by the *County* or by a *Plan Participant* will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the *Plan Participant*.

Any *Plan Participant* who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The *Plan Participant* may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("*HIPAA*"). Such standards control the dissemination of "protected health information" ("PHI") of *Plan Participant*s. Privacy standards will be implemented and enforced in the offices of the *Employer* and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take *Reasonable* steps to ensure the privacy of the *Plan Participant*'s PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The *Plan Participant*'s privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The *Plan Participant*'s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any *HIPAA* regulation modifications altering a defined *HIPAA* term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the *Plan Administrator* shall impose *Reasonable* sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The *Plan Administrator* will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written

warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the *Plan Participant*. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the *Plan Administrator* or the *Claims Administrator*, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a *Plan Participant*'s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the *HIPAA* Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the *Plan Participant*'s information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a *Plan Participant*, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as *Medicare*, etc.) in order to coordinate benefits, if a *Plan Participant* has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    (a) a public health authority or other appropriate government authority authorized by law to receive reports of *Child* abuse or neglect;
    (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    (c) locate and notify persons of recalls of products they may be using; and (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of *Child* abuse or neglect permitted by (5) above, when required or authorized by law, or with the *Plan Participant*'s agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the *Plan Participant* that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the *Plan Participant*'s PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the *Plan Participant* of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the *Plan Participant*'s PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to *Plan Participant*s: The Plan is required to disclose to a *Plan Participant* most of the PHI in a Designated Record Set when the *Plan Participant* requests access to this information. The Plan will disclose a *Plan Participant*'s PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the *Plan Participant*'s personal representative if it has a *Reasonable* belief that the *Plan Participant* has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the *Plan Participant*'s best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the *Plan Participant.*

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the *Plan Participant*'s PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the *HIPAA* Privacy Rule.

<u>Rights to Individuals</u>

The *Plan Participant* has the following rights regarding PHI about him/her:

1. Request Restrictions: The *Plan Participant* has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The *Plan Participant* may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The *Plan Participant* has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the *Plan Participant* would like to be contacted. The Plan will accommodate all *Reasonable* requests.

3. Copy of this Notice: The *Plan Participant* is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The *Plan Participant* has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The *Plan Participant* is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the *Plan Participant* of the basis of the disclosure, and certain other information. If the *Plan Participant* wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The *Plan Participant* has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the *Plan Participant* requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the *Plan Participant*'s request. If the Plan denies the request, the *Plan Participant* may be entitled to a review of that denial.

6. Amendment: The *Plan Participant* has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the *Plan Participant*'s request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the *Plan Participant* wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The *Plan Participant* may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the *Plan Participant* with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the *Plan Participant* for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Walworth County Human Resources/Benefits
100 West Walworth Street
P.O. Box 1001
Elkhorn, WI 53121
Phone: (262) 741-7950
Fax: (262) 741-7963

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (*HIPAA*).

Definitions;

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. 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.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by *Reasonable* and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement *Reasonable* and appropriate report to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each *Calendar Year*.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards