CITY OF MISHAWAKA
MISHAWAKA IN

Retirees Age 65 And Over Summary Plan Description
7670-03-411566

Revised 01-01-2018

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

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CITY OF MISHAWAKA

MEDICARE SUPPLEMENT HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as information on Your rights and obligations under the CITY OF MISHAWAKA Medicare Supplement Retiree Health Plan (the "Plan"). As a valued Retiree of CITY OF MISHAWAKA, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs by filling some of the gaps in Medicare coverage. Please read this document carefully and contact Your Human Resources Personnel office if You have questions.

CITY OF MISHAWAKA is named the Plan Administrator for this health Plan. The Plan Administrator has retained the services of an independent Third Party Administrator to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and OptumRx for pharmacy claims. Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

CITY OF MISHAWAKA assumes the sole responsibility for funding the benefits out of general assets; however, You help cover some of the costs of Covered Expenses through contributions, Deductibles, out-of-pocket and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. This Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments. The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan.

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

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

This document becomes effective on January 1, 2014.

PLAN INFORMATION

Plan Name	CITY OF MISHAWAKA Medicare Supplement Health Benefit Plan
Name and Address Of Employer	CITY OF MISHAWAKA 600 E THIRD ST MISHAWAKA IN 46544
Name, Address And Phone Number Of Plan Administrator	CITY OF MISHAWAKA 600 E THIRD ST MISHAWAKA IN 46544 574-258-1615
Named Fiduciary	CITY OF MISHAWAKA
Employer Identification Number Assigned By The IRS	35-6001115
Type of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits through a Medicare Supplement Plan.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. OptumRx provides administrative services related to pharmacy claims.
Name And Address Of Agent For Service Of Legal Process	GEOFFREY SPIESS, STAFF ATTORNEY 600 E THIRD ST MISHAWAKA IN 46544 Service of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	This Plan is funded by Retiree contributions. Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Collective Bargaining Provisions	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination.

Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new enrollees, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	January 1 thru December 31.
Compliance	It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator(s) for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator(s) shall be subject to review only if a court of proper jurisdiction determine its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrator(s) shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator(s) at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrator(s) make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan 001

This Plan helps cover a portion of Medicare and non-Medicare approved services, to the extent stated in this document. The information below will help explain how this Plan works, what the Covered Person's out-of-pocket costs will be, and how much this Plan will pay toward Covered Expenses.

All benefits payable from this Plan will be reduced by the amount that Medicare pays. This is referred to as non-duplication of benefits. Refer to the Coordination of Benefits provision in this document for more details. If a Covered Person is receiving Medicare Part A benefits, but chooses not to elect Medicare Part B, then this Plan pays nothing towards Part B services.

Services must be Medically Necessary except for covered preventive care benefits in order to be covered under this Plan.

	Benefit Level
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible*** • Per Person • Per Family	 $100 $200
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 80%
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum*** • Per Person • Per Family	 $600 $1,200
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 6 Visits 80%
Ambulance Transportation: • Paid By Plan After Deductible	 80%
Autism Services: • Paid By Plan After Deductible	 80%
Breast Pumps: • Paid By Plan	 100% (Deductible Waived)
Durable Medical Equipment: • Paid By Plan After Deductible	 80%
Contraceptive Methods And Counseling Approved By The FDA: • Paid By Plan	 100% (Deductible Waived)

	Benefit Level
Emergency Services / Treatment: • Paid By Plan After Deductible	 80%
Urgent Care: • Paid By Plan After Deductible	 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 180 Days 80%
Hearing Services: **Exams, Tests:** • Paid By Plan After Deductible **Hearing Aids:** • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible **Implantable Hearing Devices:** • Paid By Plan After Deductible	 80% $5,000 80% 80%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible. ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services***	 180 Visits 80%
Hospice Care Benefits: **Hospice Services:** • Paid By Plan After Deductible **Bereavement Counseling:** • Paid By Plan After Deductible **Respite Care:** • Paid By Plan After Deductible	 80% 80% 80%
Hospital Services - Except For Mental Health And Substance Use Disorder: **Pre-Admission Testing:** • Paid By Plan After Deductible **Inpatient Services / Inpatient Physician Charges**: **Room And Board Subject To The Payment Of Semi-Private Room Rate:** • Paid By Plan After Deductible	 80% 80%

	Benefit Level
Outpatient Services / Outpatient Physician Charges: • Paid By Plan After Deductible	80%
Imaging: • Paid By Plan After Deductible	80%
Outpatient Lab And X-ray Charges: • Paid By Plan After Deductible	80%
Outpatient Surgery / Surgeon Charges: • Paid By Plan After Deductible	80%
Manipulation Services: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	24 Visits 80%
Maternity: **Routine Prenatal Services:** • Paid By Plan	100% (Deductible Waived)
Non-Routine Prenatal Services, Delivery And Postnatal Care: • Paid By Plan After Deductible	80%
Mental Health: • Paid By Plan After Deductible	80%
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible Or Co-pay Will Be Waived For Initial Stay (Days 0-5).***	80%
Oral Surgery: • Paid By Plan After Deductible	80%
Physician Office Visit - Except For Mental Health And Substance Use Disorder: • Paid By Plan After Deductible	80%
Physician Office Services: • Paid By Plan After Deductible	80%
Preventive / Routine Care Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan After Deductible	100%
Immunizations: • Paid By Plan After Deductible	100%
Preventive / Routine Diagnostic Tests, Lab, And X-rays At Appropriate Ages: • Paid By Plan After Deductible	100%

	Benefit Level
Preventive / Routine Mammograms And Breast Exams: • Maximum Exams Per Calendar Year • Paid By Plan After Deductible	 1 Exam 100%
Preventive / Routine Pelvic Exams And Pap Tests: • Maximum Exams Per Calendar Year • Paid By Plan After Deductible	 1 Exam 100%
Preventive / Routine PSA Test And Prostate Exams: • Maximum Exams Per Calendar Year • Paid By Plan After Deductible	 1 Exam 100%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: • Paid By Plan	 100% (Deductible Waived)
Preventive / Routine Hearing Exams: • Paid By Plan	 100% (Deductible Waived)
Sterilizations: • Paid By Plan	 100% (Deductible Waived)
Substance Use Disorder And Chemical Dependency: • Paid By Plan After Deductible	 80%
Therapy Services: • Paid By Plan After Deductible ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	 80%
Vision Care Benefits: **Eye Exam:** • Maximum Exams Every 2 Years • Paid By Plan After Deductible **Refraction:** • Maximum Exams Every 2 Years • Paid By Plan After Deductible	 1 Exam 100% (Deductible Waived) 1 Exam 100% (Deductible Waived)
Wigs, (Cranial Prostheses), Toupees Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $500 80%
All Other Covered Expenses: • Paid By Plan After Deductible	 80%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 001	
Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Lifetime • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And For Up To One Year From Date of Transplant.	 80% $10,000 100% (Deductible Waived)

PRESCRIPTION SCHEDULE OF BENEFITS OPTUMRX Benefit Plan(s) 001	
Diabetic Medications To Include Insulin And All Diabetic Supplies For Endocrine/Diabetes: • Paid By Plan	 100% (Deductible Waived)
Prescription Smoking Deterrents: • Maximum Benefit Per Calendar Year	 6 Months
Annual Pharmacy Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Deductible*** • Per Person • Per Family	 $100 $200
Annual Out-Of-Pocket Maximum Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum*** • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, Then The Covered Person Pays Zero For Covered Prescription Medication.	 $600 $1,200
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) **Effective 01-01-2014 to 02-01-2014 Co-pay For Up To A 90-Day Supply By** Participating Pharmacy For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction Treating Tablets.	 For Up To A 31-Day Supply: 20% 20% $0(Deductible Waived)

Retail 90 Rx By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) **Effective 01-01-2014 to 02-01-2014 Co-pay For Up To A 90-Day Supply By** Participating Pharmacy For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction Treating Tablets.	For Up To A 3-Month Supply: (At Least 84 Days) 20% 20% $0(Deductible Waived)
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) **Effective 01-01-2014 to 02-01-2014 Co-pay For Up To A 90-Day Supply By** Participating Mail Order For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction Treating Tablets.	For Up To A 90-Day Supply: 20% 20% $0(Deductible Waived)
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To OptumRx For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule. No Benefit

Note: The Deductible and/or Co-pay may not apply to preventive Prescription and over-the-counter products and contraceptives

OUT-OF-POCKET EXPENSES AND MAXIMUMS

MONTHLY PREMIUMS

To receive coverage under this Plan, Covered Persons must pay the required monthly premium. The Plan Administrator will regularly advise Covered Persons of the required level of premiums that must be paid.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan year by the Covered Person before any Covered Expenses are paid by this benefit Plan. A Deductible applies to each Covered Person up to a family Deductible limit.

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

Pharmacy expenses count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

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

PLAN PARTICIPATION

Plan Participation means that, after Medicare pays primary:

- The Covered Person pays the Deductible.
- The Covered Person will also pay a portion of the Covered Expenses, as shown on the Schedule of Benefits, until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan pays in full after the out-of-pocket is met.

The Plan's Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses in a Calendar year, such as the Deductible and Plan Participation will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the out-of-pocket maximum of this Plan.

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

- Co-pays.
- Expenses for services that are not covered by this Plan.
- Any charges above the limits specified in this SPD.
- Any charges that exceed the Usual and Customary amount, fee schedule or Negotiated Rate paid by this Plan.
- Expenses paid by Medicare (generally), another health plan or insurance.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY (FORMER EMPLOYEES)

You are responsible for enrolling in the manner and form prescribed by Your former employer. Former employees are eligible for coverage under this Medicare Supplement Plan if all of the following requirements are met:

- You were enrolled in the active employee's health plan on the day before Your employment ended; and
- You retired from employment with CITY OF MISHAWAKA under its formal retirement program, and You are eligible for Medicare, and You declined COBRA coverage that was offered to You when Your job ended; or
- You terminated employment with CITY OF MISHAWAKA due to a disability, and You are eligible for Medicare as a result of that disability, and You declined COBRA coverage that was offered to You when Your job ended; and
- You apply for coverage under this Plan within 31 Calendar days of Retiring; and
- You meet pension requirements.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Retiree shall not also be considered an eligible Dependent under this Plan.

DEPENDENT ELIGIBILITY

Eligibility Criteria: A Dependent is eligible for coverage under this Medicare Supplement Plan if, at the time of Your retirement, the Dependent is eligible for Medicare due to age or disability.

An **eligible Dependent** includes the following people who meet the **eligibility criteria** stated above:

- Your legal spouse, as defined by the state in which You reside. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation of a Covered Person's marital status may be required by the Plan Administrator.

- Each Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following:

  - A natural biological Child;
  - A step Child;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 18 as of the date of such placement;
  - A Child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);

- A Dependent does not include the following:

  - A Child who is under the age of 26, working full-time and eligible for benefits under their employer;
  - A foster Child;
  - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - Domestic Partners.
  - Any other relative or individual unless explicitly covered by this Plan.
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

EFFECTIVE DATE OF COVERAGE

- The former employee's coverage will become effective under this Plan the day after the employee's coverage under the active employee plan ends, if You apply for coverage within 31 Calendar days following termination of employment. No coverage is available under this Plan if You apply late.

- The eligible Dependent's coverage will become effective the later of the following dates:

  - The date the retired employee's coverage begins with this Plan if the Dependent was covered under the active employee plan on the day before the employee retired; or
  - The date specified in the Special Enrollment Provision; or
  - The date specified in a Qualified Medical Child Support Order.

SPECIAL ENROLLMENT PROVISION

Note: Retirees who decline coverage in this Plan when it is initially offered are not eligible for special enrollment due to loss of other coverage, and neither are their Dependents. Similarly, Retirees who are not Covered Persons in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

LOSS OF HEALTH COVERAGE

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

- Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was first offered; and

- The coverage under another group health plan or health insurance policy was:

  - Federal COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

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

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

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

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

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

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

TERMINATION

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

A person's coverage under this Plan will end on the earliest of the following dates that applies:

- The date this Plan is terminated.
- The date coverage for the former Employee’s benefit class is terminated.
- The date You cancel coverage or fail to pay premiums as required.
- The date a false claim is submitted or any other fraudulent act is committed by You or Your Dependent related to this Plan or any other group plan.
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides.
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section; or
- The date that the former Employee dies.

COBRA CONTINUATION OF COVERAGE
Retiree Health Care Plan

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

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

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

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

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

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

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

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

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

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

- The death of the covered retired employee.

- Divorce or legal separation of the covered retired employee from the retired employee's spouse. (Also, if a retired employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 days after the divorce or legal separation, and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- A Dependent Child who no longer meets the definition of Dependent as defined in this document.

- Employer bankruptcy. Filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding is filed with respect to this employer, and that bankruptcy results in the loss of coverage of any retired employee covered under this Plan, then the retired employee is a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in the loss of their coverage under this Plan.

COBRA NOTICE PROCEDURES

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

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

A covered former employee (or Dependent's) written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Covered Person's name, their current address and complete phone number;
- The group number, name of the former employer that the former employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

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

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

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER'S OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

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

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

The Plan Administrator will notify the COBRA Administrator within 30 Calendar days from the date that notice of the Qualifying Event has been provided.

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

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

APPLYING FOR CONTINUATION COVERAGE UNDER COBRA

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

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

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

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

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

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

PAYMENT FOR CONTINUATION COVERAGE

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

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

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

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

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

A QUALIFIED BENEFICIARY'S OBLIGATIONS WHILE ON COBRA CONTINUATION

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

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

- The date any Qualified Beneficiary's marital status changes. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.

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

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

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

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

MAXIMUM LENGTH OF CONTINUATION COVERAGE

The maximum amount of time that covered Dependents can have COBRA continuation coverage is 36 months if coverage is lost due to the retired employee's death, or to divorce or legal separation, or if a Dependent no longer meets the definition of a Dependent as defined in this document.

If, however, bankruptcy of the employer is the Qualifying Event that causes loss of coverage, then the Qualified Beneficiaries can continue COBRA coverage for the following maximum period:

- The covered retired employee can continue COBRA coverage for the rest of his or her life.

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

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

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

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

- The required premium for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation, the Qualified Beneficiary becomes covered under another group plan.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (READ THIS IF THINKING OF DECLINING COBRA CONTINUATION COVERAGE)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

IF YOU HAVE QUESTIONS

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

The Plan Administrator:
CITY OF MISHAWAKA
600 E THIRD ST
MISHAWAKA IN 46544

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

TRANSITION OF CARE

This Plan provides transitional care benefits, in order to provide continuity of care for certain medical conditions already under treatment. Services may continue to be paid as in-network for up to 90 Calendar days when a provider terminates from the network.

To be eligible for this transition of care, you must have been, and continue to be, under a treatment plan by a Physician who was a member of the participating network.

Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the date the provider contract ends.
- Post-acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must complete a Transition of Care form and submit it to your Plan Administrator and receive written approval in order for You or Your Dependent to be eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS
(Additional Details)

This Plan covers a portion of the same Medically Necessary benefits that Medicare covers, subject to any limitations that Medicare has. The Plan also provides other benefits for Covered Persons. Please refer to the Schedule of Benefits in this SPD for what this Plan covers, and to Your Medicare booklets for information on what Medicare covers.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.

2. **Acupuncture Treatment**.

3. **Allergy Treatment** including injections, testing and serum.

4. **Ambulance Transportation**: Medically Necessary ground Ambulance Transportation by a vehicle designed, equipped and used only to transport the sick and injured to the closest facility for emergencies. Air ambulance is only covered in Emergency situations where serious danger to Your life or health may occur if You were transported by ground ambulance. Transportation from a Hospital or Skilled Nursing Facility to another location is generally not covered unless transportation in any other vehicle would endanger Your health. All ambulance suppliers must accept Medicare Assignment.

5. **Anesthetics and their Administration** while You are in an Inpatient Hospital, or being treated on an Outpatient basis.

6. **Augmentation Communication Devices** and related instruction or therapy.

7. **Autism Spectrum Disorders (ASD) Treatment,** when Medical Necessity is met.

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

   ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.

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

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

   Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

Does not include services or treatment identified elsewhere in the Plan as noncovered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

8. **Blood** that You get on an Inpatient or Outpatient basis.

9. **Braces** for arms, legs, back and neck.

10. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

11. **Breast Prostheses** (including a surgical brassiere) after a mastectomy.

12. **Cardiac Rehabilitation**: Rehabilitation programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

13. **Cataract or Aphakia Surgery.** See also eye glasses.

14. **Chemotherapy.**

15. **Contraceptives and Counseling For Women Only:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that a Covered Person self-administers will be processed under the Prescription Benefits section of this document (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

16. **Dental**: A serious dental condition requiring Inpatient treatment or Outpatient treatment in a Hospital, a surgical day care unit, or a participating ambulatory surgical center will be covered for: Surgical removal of unerupted teeth or impactions in the bone; extraction of seven or more permanent teeth at one time; reduction of a fracture; gingivectomies involving two or more gum quadrants; excision of a tumor (except that a radicular cyst must involve the roots of three or more teeth). When these procedures can be performed safely in a dentist's office, there is no coverage under this Plan.

17. **Diabetes Treatment**: Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. Charges for dialysis for the treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

18. **Durable Medical Equipment**: The equipment must be prescribed by a Physician for use in Your home. Durable Medical Equipment must be durable, used for medical reason, and must not usually be useful to someone who is not sick or injured. DME items can only be obtained from a supplier who accepts Medicare assignment. The amount that You pay can vary. Medicare requires that some equipment be rented, and other equipment must be purchased. The type of Durable Medical Equipment that Medicare may cover includes, but is not limited to: Air fluidized beds, blood glucose monitors, commode chairs, crutches, home oxygen equipment and supplies, hospital beds, infusion pumps, nebulizers, patient lifts to lift patient from a bed or wheelchair, suction pumps, traction equipment, walkers, and wheelchairs.

19. **Emergency Room Hospital and Physician Services** when Your health is in serious danger. (Emergency services are generally not covered in foreign countries).

20. **Emergency Services Provided in a Foreign Country,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or physician services in a Provider's office, as shown in the Schedule of Benefits.

21. **Eye Glasses**: Following cataract surgery with an intraocular lens, the Plan will help pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare. Only standard frames are covered.

22. **Foot Care**: Medically Necessary treatment of Injuries or diseases of the foot, including:

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

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

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

    Genetic Testing MUST meet the following requirements:

    The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

And must meet at least one of the following:

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

Generally, genetic testing is not covered for:

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

25. **Hearing Services** include:

- Exams, tests, services and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids.
- Implantable hearing devices.

26. **Home Health Care Services**: Intermittent skilled nursing care, physical therapy, speech language pathology services or occupational therapy services that You get in Your home for the treatment of an Illness or Injury. You must be considered homebound as defined by Medicare. The home health agency must be approved by the Medicare program.

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

- **Assessment**: Includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
- **Inpatient Care**: In a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
- **Outpatient Care**: Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Respite Care** to provide temporary relief for 48 hours per Calendar year to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.
- **Bereavement Counseling**: Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist.

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

28. **Hospital Services (Includes Inpatient Services and Ambulatory Surgery Centers). The following benefits are covered:**

    - Semi-Private Room and Board.
    - Intensive Care Unit Room and Board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

29. **Kidney Dialysis** as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

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

31. **Macular Degeneration** treatment for people with age-related macular degeneration. The treatment is referred to as ocular photodynamic therapy with verteporfin.

32. **Manipulations**: Manipulation of the spine to correct a subluxation.

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

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

34. **Mental Health Treatment** needed on an Inpatient or Outpatient basis to help diagnose and treat mental health conditions, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare. Pervasive developmental disorder and neurobiological disorders are covered.

35. **Nursery and Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

36. **Nutritional Supplements, Vitamins and Electrolytes** when the sole source of nutrition:

    - Prescribed by a Physician and administered through enteral feedings.
    - Supplies related to enteral feedings.

37. **Nutrition Therapy Services** for people with diabetes, kidney disease (if not on dialysis), and after a kidney transplant when referred by a Physician. Nutritional assessment, therapy and counseling can be provided by a registered dietician or Medicare-Approved nutrition professional.

38. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Excision of exostosis of jaws and hard palate.

39. **Oxygen Therapy**. The Plan covers rental of oxygen equipment, or if You own Your own equipment, the Plan will help pay for oxygen contents and supplies for the delivery of oxygen if approved by Medicare. Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.

40. **Physician Office Visits** for Medically Necessary services and covered preventive medical care.

41. **Pre-Admission Testing.**

42. **Prescription Drugs** if approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

43. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

44. **Prosthetic Devices** needed to replace a body part or function, and as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

45. **Radiation Therapy.**

46. **Routine Care (Preventive Care)** as listed on the Schedule of Benefits, if applicable, including:

- Colorectal cancer screening.
- Bone mass measurements.
- Glaucoma screening.
- Mammogram screening.
- Pap test and pelvic examination.
- Prostate cancer screening.
- Vaccinations.

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

48. **Skilled Nursing Facility Care**: The Plan will pay for care when a Covered Person is transferred to a Skilled Nursing Facility from a Hospital if:

    - The Covered Person was hospitalized for 3 or more consecutive days, not including the day You leave the Hospital; and
    - You enter the Skilled Nursing Facility within 30 days after leaving the Hospital for the same or related reason that You were in the Hospital, as required by Medicare; and
    - Your doctor has stated that You need daily skilled care and that it must be provided by skilled nursing or rehabilitation staff.

49. **Sleep Disorders if Medically Necessary.**

50. **Sleep Studies.**

51. **Sterilizations.**

52. **Substance Use Disorder Services** to the extent approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

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

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

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Speech therapy** by a Qualified speech therapist.

55. **Transplant Services** means human to human transplant procedures which at the time sought to be provided are approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

56. **Wigs, (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

57. **X-rays** for Medically Necessary diagnostic X-rays that are ordered by Your treating Physician.

PRESCRIPTION DRUG BENEFITS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits.

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan. Any pre-existing provisions of this Plan do not apply to Prescription Drug Benefits.

Medicare Part D

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. In addition, electing Medicare part D may affect Your ability to get Prescription coverage under this benefit. Medicare eligible individuals should have received a notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. For a copy of this notice, please contact the Plan Administrator.

Identification Card (ID Card) – Network Pharmacy

You must either show Your ID card at the time You obtain Your Prescription Drug at a Network Pharmacy or provide the Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If You don't show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2 and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, as frequently as monthly, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through mail order. Your Co-pay or Participation will also depend on whether or not You visit the pharmacy or use the mail order service; see the Prescription Schedule of Benefits for further details. Here's how the tier system works:

Tier 1 is Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

Tier 2 is Your middle Co-pay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.

Tier 3, if applicable, is Your highest Co-pay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs at a retail Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that OptumRx agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount; or
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 877-559-2955.

To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the Co-pay, Participation, or Deductible amount. The Plan pays benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

Note: Pharmacy Benefits apply only if Your prescription is for a Covered Expense, and not for Experimental, Investigational, or Unproven Services. Otherwise, You are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow You to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic Illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all You need to do is complete a patient profile and enclose Your Prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can reach OptumRx at 877-559-2955.

The Plan pays mail order benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

You may be required to fill an initial Prescription Drug order and obtain one or more refills through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-pay, Participation, or Deductible amount for any Prescription order or refill if You use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure Your Physician writes Your mail order or refill for a 90-day supply, not a 31-day supply with three refills.

Designated Pharmacy

If You require certain Prescription Drugs, OptumRx may direct You to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the Definitions in this section for the definition of Designated Pharmacy.

Want to lower Your out-of-pocket Prescription Drug costs?

Consider tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

OptumRx Pharmacy and Therapeutics (P&T) Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the P&T Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or notification requirements should apply.

Economic factors may include:

- The acquisition cost of the Prescription Drug; and
- Available rebates and assessments on the cost effectiveness of the Prescription Drug.

When considering a Prescription Drug for tier placement, the P&T Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The P&T Committee may periodically change the placement of a Prescription Drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to You.

Prescription Drug, Prescription Drug List (PDL), and P&T Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide You and Your Physician in choosing the medications that allow the most effective and affordable use of Your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain prior authorization. OptumRx will determine if the Prescription Drug, in accordance with Your plan's approved guidelines, is both:

- A Covered Expense as defined by the Plan; and
- Not Experimental, Investigational or Unproven.

The Plan may also require You to obtain a prior authorization so OptumRx can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or You are responsible for obtaining prior authorization from OptumRx.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, You or Your Physician are responsible for obtaining prior authorization from OptumRx as required.

To determine if a Prescription Drug requires prior authorization, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after OptumRx reviews the documentation provided and determines that the Prescription Drug is not a covered health service or it is an Experimental, Investigational, or Unproven service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 877-559-2955.

Limitation on Selection of Pharmacies

If OptumRx determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, You may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955. Whether or not a Prescription Drug has a supply limit is subject to OptumRx' periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and OptumRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name drug may change. As a result, Your Co-pay, Participation, or Deductible amount may change. You will pay the amount applicable for the tier to which the Prescription Drug is assigned.

Special Programs

CITY OF MISHAWAKA and OptumRx may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 877-559-2955.

Rebates and Other Discounts

OptumRx and CITY OF MISHAWAKA may, at times, receive rebates for certain drugs on the PDL. OptumRx does not pass these rebates and other discounts on to You, nor does OptumRx take them into account when determining Your Co-pays.

OptumRx and a number of its affiliated entities conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants, and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. OptumRx is not required to pass on to You, and does not pass on to You, such amounts.

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

- **Prescription products which are:**
  - Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
  - Can be obtained only by Prescription and are dispensed in a container labeled “Rx only”; and

- The following non-prescription products prescribed by a duly licensed medical professional:
  - Compounded medications of which at least one ingredient is a Prescription Drug;
  - Any other medications which due to state law may only be dispensed when prescribed by a duly licensed medical professional; and
  - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.

- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

- **Mail Order Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for prescription products dispensed through the mail order pharmacy identified by OptumRx. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each prescription or refill. The Co-pay is shown on the Prescription Schedule of Benefits. By law, prescription products cannot be mailed to a Covered Person outside the United States.

- **Diabetic Medications** to include insulin and all diabetic supplies.

Covered Expenses apply to only certain Prescription Drugs and supplies, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955, for information on which Prescription Drugs are excluded.

Excluded medications are:

- For any condition, Injury, sickness or Mental Health Disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;

- Available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a Calendar year, and the Plan may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision;
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription order or refill. Compounded drugs that are available as a similar, commercially available Prescription Drug;
- Dispensed outside of the United States, except in an Emergency;
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- The amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
- Prescribed, dispensed, or intended for use during an Inpatient stay;
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that CITY OF MISHAWAKA determines do not meet the definition of a Covered Expense;
- Used for conditions and/or at dosages determined to be Experimental, Investigational, or Unproven, unless OptumRx and CITY OF MISHAWAKA have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Vitamins, except for the following, which require a Prescription:
  - Prenatal vitamins;
  - Vitamins with fluoride; and
  - Single-entity vitamins.

DEFINITIONS

Brand-name means a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by OptumRx as a Brand-name drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-name by OptumRx.

Co-payment (or Co-pay) means the set dollar amount You are required to pay for certain Prescription Drugs.

Designated Pharmacy means a pharmacy that has entered into an agreement with OptumRx, or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by OptumRx as a Generic drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Generic" by the manufacturer, pharmacy, or Your Physician may not be classified as Generic by OptumRx.

Network Pharmacy means a retail or mail order pharmacy that has:

- Entered into an agreement with OptumRx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by OptumRx as a Network Pharmacy.

Participation means the percentage of the cost You are required to pay for certain Prescription Drugs.

PDL: see Prescription Drug List (PDL).

Pharmacy and Therapeutics P&T Committee means the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prescription Drug means a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a Prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Insulin syringes with needles;
  - Blood testing strips - glucose;
  - Urine testing strips - glucose;
  - Ketone testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose monitors.

Prescription Drug Charge means the rate OptumRx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.UMR.com, and navigating to the myPharmacyCenter section, or calling OptumRx at 877-559-2955.

Therapeutic Class means a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. Prescription drug coverage under Medicare Part D will be coordinated under the Medicare Secondary Payer Rules The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

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

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

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as Skilled Nursing Care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

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

ORDER OF BENEFIT DETERMINATION RULES

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

- Any plan that has no coordination of benefits provision will pay first.

- This Plan will coordinate benefits in a manner that will comply with the Medicare Secondary Payer regulations. The following are examples of how the MSP rules work:

    - If You or Your Dependent are actively employed and covered under an employer's group health plan or policy, the active plan pays first for both the employee and the spouse. Medicare pays second, and any retiree health care coverage would pay third.
    - If You and Your spouse are retired and age 65 or older, Medicare pays first and any retiree plan pays second.

- For a Covered Person with End Stage Renal Disease (ESRD), an employer's group health plan covering active employees has primary responsibility for payment for 30 months from the date the Covered Person has Medicare eligibility based upon ESRD. At the end of 30 months, Medicare becomes the primary plan, any employer group health plan covering active employees would pay second, and any retiree plan would pay third.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- The plan that covers the person as an employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or Retirees.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers the Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. (See continuation coverage below). (There may also be exceptions due to Medicare Secondary Payor Rules).

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

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

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

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years starting after the plan is given notice of the court decree.

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

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

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

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary, unless the Medicare Secondary Payer rules require COBRA to be primary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored.

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

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

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

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

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

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

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.

- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.

- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

    - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.

- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

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

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

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

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

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

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

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

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

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

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

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

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

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

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

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

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

GENERAL EXCLUSIONS

The Plan does not apply exclusions to treatment listed in the Covered Services section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions**: Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

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

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

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

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

6. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

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

8. **Biofeedback Services**.

9. **Blood** donor expenses.

10. **Blood Pressure Cuffs / Monitors.**

11. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

12. **Chelation Therapy**, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

13. **Claims** received after the proof of loss deadline.

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

15. **Contraceptive Products**, including medications, devices, patches or injectables used for birth control.

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

17. **Counseling Services** in connection with marriage, pastoral, nutritional or financial counseling.

18. **Court-Ordered**: Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

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

20. **Custodial Care** as defined in the Glossary of Terms.

21. **Dental Services**:

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

22. **Duplicate Services and Charges** including the preparation of medical reports and itemized bills.

23. **Education**: Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Employment/Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, where required by law.

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

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

27. **Excess Charges**: Charges or the portion thereof which are in excess of the Usual and Customary charge or the Negotiated Rate.

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

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

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

31. **Foot Care (Podiatry):** Routine foot care.

32. **Foreign Coverage for Medical Care Expenses Which Includes Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.

33. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.

34. **Genetic Testing** unless covered elsewhere in this SPD.

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

36. **Infertility Treatment** and direct attempts to achieve pregnancy by any means.

37. **Lamaze Classes** or other child birth classes.

38. **Lasik Surgery, Radial Keratotomy, Refractive Keratoplasty** or similar surgery used to improve eye sight or refractive disorders.

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

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

41. **Mammoplasty or Augmentation** unless covered elsewhere in this SPD.

42. **Marriage Counseling.**

43. **Massage Therapy**.

44. **Maternity Costs** for Covered Persons other than the employee or spouse.

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

46. **Medicare**: Charges for care and treatment of an Illness or Injury that is not approved by Medicare (except to the extent non-Medicare benefits are specifically provided for on the Schedule of Benefits).

47. **Methadone Treatment** as maintenance.

48. **Midwife**: Services of a midwife are not covered.

49. **Military**: A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

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

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

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

53. **Not Medically Necessary**: Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.

54. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

55. **Nutrition Counseling** unless covered elsewhere in this SPD.

56. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

57. **Orthopedic Shoes**.

58. **Over-the-Counter Medication**, **Products, Supplies or Devices** unless covered elsewhere in this SPD.

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

60. **Pharmacy Consultations:** Charges for or relating to consultative information provided by a pharmacist regarding a Prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

61. **Private Duty Nursing Services**.

62. **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, except as required under the Women's Health and Cancer Rights Act.

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

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

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

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

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

68. **Services** that should legally be provided by a school.

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

70. **Sex Therapy**.

71. **Sexual Function**: Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits section in this SPD) in connection with treatment for male or female impotence.

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

73. **Skilled Nursing Care**: Any Skilled Nursing Facility services which exceed the appropriate level of skill required for treatment as determined by the Plan.

74. **Specialty Drugs.**

75. **Standby Surgeon Charges.**

76. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

77. **Surrogate Motherhood or Gestational Carrier Services** including any services or supplies provided in connection with a surrogate pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate mother.

78. **Taxes**: Sales taxes, shipping and handling unless covered elsewhere in this SPD.

79. **Telemedicine or Telephone or Internet Consultations** except as approved by Medicare.

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

81. **Tobacco Addiction**: Services, treatment or supplies related to addiction to or dependency on tobacco.

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

83. **Travel**: Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

84. **Vision Care**: Routine eye care or the purchase or fitting of eyeglasses or contacts, except as allowed by Medicare following cataract surgery.

85. **Vitamins, Minerals and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections that are prescribed by a Physician for Medically Necessary purposes.

86. **Vocational Services**: Vocational and educational services rendered primarily for training or education purposes.

87. **Warning Devices**: Warning devices, stethoscope or other types of apparatus used for diagnosis or monitoring.

88. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to a covered pregnancy that is expected to result in childbirth.

89. **Weight Control**: Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness.

90. **Wigs, (Cranial Prostheses, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving**, or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

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

TYPE OF CLAIMS AND DEFINITIONS

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with Medicare on the Covered Person's behalf. If the Covered Person gives UMR his or her Medicare identification number, then Medicare will automatically send information to UMR stating how much Medicare has paid toward Covered Expenses, and how much the Covered Person is responsible for paying. If Medicare states that the Covered Person owes a certain amount toward the bill, then UMR will process the claim according to the provisions in this document to see if this Plan can help cover some of the Covered Person's remaining costs.

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

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits to OptumRx under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the Pharmacy drug benefit identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should contact the number on the back of the Pharmacy drug benefit identification card for further insurrection on how to proceed.

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

A complete claim should include the following information:

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

TIMELY FILING

Complete claims must be submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Covered Persons can request a Prescription claim form by writing OptumRx at PO Box 8082, Wausau WI 54402-8082 or by calling the number on the back of the Prescription drug card. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

HOW HEALTH BENEFITS ARE CALCULATED

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

If Medicare approves a claim, then this Plan will use not more than 100% of the Medicare-Allowed amount as the starting point when determining how much this Plan will pay toward that Claim, if anything. If Medicare does not approve a claim, then this Plan pays Covered Expenses according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible or other out-of-pocket expenses that the Covered Person is responsible for paying, and subject to the Coordination of Benefits provision.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible or other out-of-pocket expenses that the Covered Person is responsible for, and subject to the Coordination of Benefits provision.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. The U&C guidelines do not apply to In-network claims, which are governed by the network contract. The allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

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

Note: For Prescription benefits, Covered Persons will receive an EOB when a Covered Person files a claim directly with OptumRx. Please see Procedures For Submitting Claims (above) for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

- Post-Service Claims: Claims will be processed within 30 Calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment authorization ending or being reduced.

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Covered Person is no longer eligible for coverage under the Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Covered Person or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Covered Person is responsible for charges due to Deductible or other out-of-pocket expense obligations.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Authorized Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above.

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

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

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

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

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

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

Send Pharmacy appeals to:
OPTUMRX
PO BOX 8082
WAUSAU WI 54402-8082

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

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

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

LEGAL ACTIONS FOLLOWING APPEALS

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

FRAUD

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

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

Covered Persons must:

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

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

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

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

OTHER FEDERAL PROVISIONS

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must cover the following medical and surgical procedures for breast reconstruction following a covered mastectomy:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and complications of mastectomies, including lymphedemas.

This coverage is subject to the same annual Deductibles and coinsurance levels that are required for any other medical or surgical procedure under the Plan.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

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

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

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

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

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

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

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

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

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

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

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

Controller, Director of Human Resources, Assistant Director of Human Resources, Mayor, Safety Director, Staff Attorney, Human Resource Office Manager

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

DEFINITIONS

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

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

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

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

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

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

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

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

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;

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

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

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

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

Plan Sponsor means Your employer.

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

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

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

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

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

PLAN AMENDMENT AND TERMINATION INFORMATION

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

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

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

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

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

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

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

In accordance with ERISA, post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily injury.

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

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

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

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

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

Assignment (in the original Medicare Plan) means that the Covered Person's Part B provider has agreed to accept the Medicare-Approved amount as payment in full. The Covered Person still needs to pay any applicable Deductible and Plan Participation amounts. If a provider does not accept assignment, the Covered Person may pay more for services.

Benefit Period: A Benefit Period begins the day You go into a Hospital or skilled nursing facility, and ends when You haven't received any Hospital or Skilled Nursing Facility Care for 60 days in a row. If You go into the Hospital after one Benefit Period has ended, a new Benefit Period begins.

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

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

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

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

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

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

Covered Person means a Retiree or Dependent who is enrolled under this Plan.

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

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

Dependent – see Eligibility and Enrollment section of this SPD.

Durable Medical Equipment means equipment which:

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

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

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

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

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

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

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

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

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

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

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

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

Hospital means:

- A facility that is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for Custodial or maintenance Care.

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

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

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

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

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

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

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

Limiting Charge means the highest amount of money You can be charged for a covered service by Physicians and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The Limiting Charge only applies to certain services and does not apply to supplies or equipment.

Lifetime Reserve Days means the 60 days that Medicare will pay for when the Covered Person is in a Hospital more than 90 days during a Benefit Period. These 60 reserve days can be used only once during the Covered Person's lifetime. For each Lifetime Reserve Day, Medicare will pay all covered costs except for the daily coinsurance amount.

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

Medically Necessary or Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury and which meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a medical condition; and
- Is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- Is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- Is cost effective for this condition, compared to alternative interventions, including no intervention. Cost effective does not necessarily mean the lowest price; and
- Not primarily for the convenience or preference of the Covered Person, his or her family or any provider; and
- It is not Experimental, Investigational, Cosmetic or Custodial in nature; and
- Is currently or at the time the charges were Incurred recognized as acceptable medical practice by the Plan.

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

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

Medicare-Approved Amount means the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by You and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge".

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

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

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

Outpatient Prospective Payment System means the system that Medicare uses to pay for services that the Covered Person receives at a Hospital, community mental health center and other facilities as an Outpatient.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), or a certified nurse midwife (CNM) , or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

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

Plan means CITY OF MISHAWAKA Medicare Supplement Group Health Plan.

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

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

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

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventative/Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

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

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

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

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

Skilled Nursing Facility Care means an institution that has a transfer agreement with one or more Hospitals. For the most part, it provides inpatients with skilled nursing care and related services. The facility must be licensed by the state in which it operates as a Skilled Nursing Facility. Any service that could be safely done by an average non-medical person (or by one's self) without the supervision of a registered nurse is not considered skilled care.

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

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

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

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

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

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

That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

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

You, Your means the Retired person.