AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: 2016 NGS CoreSource Health Plan

Action Requested: County Manager Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Please see the attached.

Fiscal Impact:

Submitted by: Katherine Haase for Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
No concerns. ln

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 2/18/2016

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok - gs

Reveiwed by: GUNCOUNTY1\gstuhr Discharge Date: 2/22/2016 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/22/2016

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted:

Agenda Date: 3/1/2016

Revised April 2015

GUNNISON COUNTY, COLORADO

YOUR HEALTH PLAN & YOU

NGS CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

Dear Participant,

Welcome to the health plan provided to you and your eligible family members by Gunnison County, Colorado! Please take some time to review this booklet to help you maximize your benefit program. Then keep it handy where you can refer to it whenever needed.

This booklet includes the following sections:

Overview of Benefits: This section of the plan provides a brief, easy-to-read outline of benefits for your reference. It also describes the important criteria to which all treatment, services or supplies provided by this plan are subject. For more comprehensive information about a particular benefit, please refer to the "Benefit Details," "Disease Specific Treatments," or "Supplementary Services and Supplies" section of the plan.

Prevention and Health Management: The plan encourages you to obtain appropriate preventive care and to develop a lifestyle which promotes health and well-being. We want you to reach your highest health potential!

Network Access: The plan has been designed to provide you with high quality benefits that are also affordable. When you use a **network provider**, your patient liability amounts will be less than they would be if you sought services outside the network. This section fully explains how to find a **network provider**, the advantages of using **network providers**, and what happens if you are in an **emergency** situation and cannot use a **network provider**.

Plan Structure: The plan contains certain cost share responsibilities, such as **deductibles** and **out-of-pocket maximums** and provisions such as pre-certification which are outlined in this section of the plan. The information includes descriptions to help you fully understand how the plan is structured.

Benefit Details, Disease Specific Treatments, and Supplementary Services and Supplies: When you do need medical services, these sections describe the benefits available for each type of service – from Ambulance to X-ray. Benefits listed in these sections are subject to the criteria outlined in the "What Is Covered?" and "What Is Not Covered?" sections of the plan.

Participating in the Plan: This section explains the plan's eligibility requirements for you and your family members, when your coverage begins and ends, and what happens when you experience a change in status.

Other Important Information: This plan also provides general information regarding your rights to continue coverage, how this plan works with other coverage, how to submit claims and what to do if you disagree with a claim decision, as well as other information you may find helpful in understanding your benefits.

This plan is intended to comply with all provisions of any federal acts and/or applicable court decisions which set forth a precedent. This plan shall be deemed to be amended to minimum standards required by these acts and/or applicable court decisions, as interpreted by the **Plan Administrator**.

This plan is intended to comply with all provisions of any federal acts and/or applicable court decisions which set forth a precedent. This plan shall be deemed to be amended to minimum standards required by these acts and/or applicable court decisions, as interpreted by the **Plan Administrator**.

Having a benefit plan to provide support in assisting you and your eligible family members with maximizing health and to provide benefits during a time of **illness** and **injury** is a significant advantage that also comes with responsibility. Remember that you have the responsibility to:

- Learn more about your health and about this health plan.
- Help make decisions about your health care.
- Give your **physician** the best information that you can about your health so they can help you get the care you need.
- Follow your **physician's** instructions about your health care.
- Focus now on living a healthy lifestyle!

We look forward to serving you! If you have questions about this plan, your health care, any supplementary plan benefits, or need additional information, please do not hesitate to contact NGS CoreSource.

NGS CoreSource
P.O. Box 2310
Mt. Clemens, MI 48046
(800) 521-1555

For your convenience, you may also visit the NGS CoreSource website at www.ngscoresource.com.

On the website, you can access your enrollment and claims information at any time of the day or night through the NGS CoreSource Info Center. Simply click on the Create an Account button and follow the simple steps to register.

If you need assistance with registering, you can contact our Help Desk at (800) 521-1555.

Important Phone Numbers

Name	Telephone Number
Your Doctor (primary care):	
Your Doctor:	
Your Doctor:	
Your Hospital:	
Your Pharmacy:	
Your Medications	
Important Contact Information	
NGS CoreSource	1-800-521-1555
CVS Caremark	1-866-818-6911
EAP (TRIAD)	1-877-679-1100
Medicare Helpline For help with questions about **Medicare**	1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048
Social Security Administration For help with questions about eligibility for and enrolling in **Medicare**, Social Security retirement benefits, or disability benefits.	1-800-772-1213 TTY: 1-800-325-0778

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OVERVIEW OF BENEFITS PPO PLAN

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan as indicated in the following pages.

	Network	Non-Network
Deductible applies to essential and non-essential benefits. • Individual • Family (One member meets $800 – all others meet additional $800)	$800 $1,600	$800 $1,600
Medical Out-Of-Pocket (Includes medical **deductible** and medical co-pays) applies to essential and non-essential benefits. • Individual • Family (One member meets $3,200-all others meet additional $3,200)	$3,200 $6,400	Unlimited Unlimited
Prescription Out-Of-Pocket (Includes prescription **deductible** and prescription co-pays) • Individual • Family (One member meets $3,000 – all others meet additional $6,000)	$3,000 $6,000	Unlimited Unlimited
The Network **deductible** and **out-of-pocket maximum** does not apply to Non-Network **deductible** and **out-of-pocket maximum**. The Non-network **deductible** and **out-of-pocket maximum** does not apply to Network **deductible** and **out-of-pocket maximum**.		
Annual Maximum	Unlimited	
ESSENTIAL BENEFITS		
Hospital-Inpatient • Facility and Physician	80% after **deductible**	60% after **deductible**
Surgery • Facility and Physician	80% after **deductible**	60% after **deductible**
Hospital Visits	80% after **deductible**	60% after **deductible**
Emergency Room • Emergencies	80% after **deductible**	80% after **deductible**
Urgent Care	80% after **deductible**	60% after **deductible**

	Network	Non-Network
Ambulance	80% after **deductible**	80% after **deductible**
Anesthesia	80% after **deductible**	60% after **deductible**
Blood	80% after **deductible**	60% after **deductible**
Cardiac Rehabilitation	80% after **deductible**	60% after **deductible**
Chemotherapy	80% after **deductible**	60% after **deductible**
Consultations • Inpatient • Outpatient: ○ Gunnison County Family Physicians ○ Network Physicians ○ Specialists	80% after **deductible** 100% after **$20** co-pay 100% after **$40** co-pay 100% after **$60** co-pay	60% after **deductible** 60% after **deductible** 60% after **deductible** 60% after **deductible**
Contraceptives (All FDA approved devices diaphragms, implants, injections, and IUD's, including patient education and counseling)	100% no **deductible**	Not Covered
Dialysis **Renal Dialysis Services** (will be payable subject to 200% of the Medicare allowable amount)	80% after **deductible**	60% after **deductible**
Fertility Testing, Testing to determine cause and surgical procedures to correct infertility	80% after **deductible**	60% after **deductible**
Home Health Care (120 visits per calendar year)	80% after **deductible**	60% after **deductible**
Hospice	80% after **deductible**	60% after **deductible**
Implants	80% after **deductible**	60% after **deductible**
Injections	80% after **deductible**	60% after **deductible**
Laboratory Testing	80% after **deductible**	60% after **deductible**
Medical Equipment and Supplies	80% after **deductible**	60% after **deductible**
Medical Supplies	80% after **deductible**	60% after **deductible**
Mental Disorders/ Substance Abuse Expenses • Inpatient • Outpatient	80% after **deductible** 80% after **deductible**	60% after **deductible** 60% after **deductible**
Occupational Therapy (60 visits in a calendar year)	80% after **deductible**	60% after **deductible**
Office Visits • Gunnison County Family Physicians • Network Physicians • Specialists	100% after **$20** co-pay 100% after **$40** co-pay 100% after **$60** co-pay	60% after **deductible** 60% after **deductible** 60% after **deductible**

	Network	Non-Network
Orthotics	80% after **deductible**	60% after **deductible**
Physical Therapy (60 visits in a calendar year)	80% after **deductible**	60% after **deductible**
Pregnancy Related Expenses-Mother		
• Initial visit, Pre-/Post-natal visit	100% no **deductible**	60% after **deductible**
• Subsequent Visits	80% after **deductible**	60% after **deductible**
Prescription Drugs		
Annual Prescription Deductible	$100	N/A
Retail		
• Preventive, as required by PPACA	$0 co-pay, no **deductible**	Not Covered
• Generic		
-30-day supply	$5 co-pay	Not Covered
-60-day supply	$10 co-pay	Not Covered
-90-day supply	$15 co-pay	Not Covered
• Formulary/Preferred Brand (co-pay per 30 day supply)	25%, a minimum of $35, maximum of $150*	Not Covered
• Non-Formulary/Non-Preferred Brand (co-pay per 30 day supply)	25%, minimum of $70, maximum of $150*	Not Covered
Mail Order (co-pay per 30 day supply)		
• Preventive, as required by PPACA	$0 co-pay, no **deductible**	Not Covered
• Generic	$10.00 co-pay	Not Covered
• Formulary/Preferred Brand	25%, Minimum of $80.00*	Not Covered
• Non-Formulary/Non-Preferred Brand	25%, Minimum of $80.00*	Not Covered
Specialty Drugs (limited to a 30 day supply and must be purchased from CVS Caremark Specialty Pharmacy)		
• Generic	15%, a maximum of $150	Not Covered
• Preferred Brand	15%, a maximum of $150*	Not Covered
• Non-Preferred Brand	15%, a maximum of $150*	Not Covered

* If a generic is available but the member requests a brand name drug, the member is responsible for brand co-pay plus any cost differential between brand name and the generic drugs. The difference may apply to the deductible.

	Network	Non-Network
Preventive Care (As described by the United States Preventive Services Task Force (USPSTF))		
• Annual visit, including well baby visit	100% no **deductible**	Not Covered
• Testing	100% no **deductible**	Not Covered
• Bone Density Testing	100% no **deductible**	60% after **deductible**
• Immunizations	100% no **deductible**	Not Covered
• Cancer screenings - Pap smears - Mammogram - PSA	100% no **deductible**	Not Covered
• Colonoscopy	100% no **deductible**	60% after **deductible**
	Please refer to www.uspreventiveservicestaskforce.org for additional information and limitations.	
Preventive Care • Women's Preventive Care - Well woman visits - Screening for gestational diabetes - Human papillomavirus testing - Counseling for sexually transmitted infections - Counseling and screening for human immune deficiency virus - Contraceptive methods and counseling - Breastfeeding support, supplies and counseling - Screening and counseling for interpersonal and domestic violence	100% no **deductible**	Not Covered
	Please refer to www.hrsa.gov/womensguidelines for additional information and limitations.	
Prosthetic Devices	80% after **deductible**	60% after **deductible**
Radiation Therapy	80% after **deductible**	60% after **deductible**
Skilled Nursing Facility (120 days per confinement)	80% after **deductible**	60% after **deductible**

	Network	Non-Network
Speech Therapy (60 visits in a calendar year)	80% after **deductible**	60% after **deductible**
Sterilization • Female employee, spouse/dependent child • Male employee/spouse	100% no **deductible** 80% after **deductible**	Not Covered Not Covered
Substance Abuse Expenses • Inpatient • Outpatient	80% after **deductible** 80% after **deductible**	60% after **deductible** 60% after **deductible**
Transplants	80% after **deductible**	60% after **deductible**
Vision Services	80% after **deductible**	60% after **deductible**
Weight Management	Payment is based on service rendered	Payment is based on service rendered
X-rays	80% after **deductible**	60% after **deductible**
All Other Covered Expenses	80% after **deductible**	60% after **deductible**
MEDICAL EXPENSES – NON - ESSENTIAL BENEFITS		
	Network	**Non-Network**
Alternative Medicine ($1,000 per calendar year) Acupuncture/Acupressure, Therapeutic Massage, Nutrition Therapy, Rolfing, and Naturopathy Care	100% after $40 co-pay	60% after **deductible**
Chiropractic Care ($500 in a calendar year)	80% after **deductible**	60% after **deductible**
Hearing Exam, Testing, Hearing Aids, Implants and Devices $4,500 (combined), once every five years)	80% after **deductible**	60% after **deductible**

NOTE: This is only a brief overview of benefits. Please refer to the following sections of this plan for complete information on the eligibility provisions, limitations and for all other terms of the plan. Any maximums listed are applicable to all plan levels.

OVERVIEW OF BENEFITS HDHP/HSA PLAN

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan as indicated in the following pages.

	Network	Non-Network
Deductible applies to essential and non-essential benefits • Individual • Family **Deductibles** do not cross apply	$4,000 $8,000	$8,000 $16,000
Employer HSA Portion of the Deductible • Individual • Family	$600 $1,200	$600 $1,200
Out-Of-Pocket (Calendar year - includes **deductible**, co-pays and co-insurance) applies to essential and non-essential benefits • Individual • Family Out-of-pockets do not cross apply	$4,000 $8,000	$10,000 $20,000
Annual Maximum For Essential Benefits	Unlimited	
ESSENTIAL BENEFITS		
Hospital-Inpatient • Facility and Physician	100% after **deductible**	60% after **deductible**
Surgery • Facility and Physician	100% after **deductible**	60% after **deductible**
Hospital Visits	100% after **deductible**	60% after **deductible**
Emergency Room • Emergencies **Urgent Care**	100% after **deductible** 100% after **deductible**	100% after **deductible** 60% after **deductible**
Ambulance	100% after **deductible**	100% after **deductible**
Anesthesia	100% after **deductible**	60% after **deductible**

	Network	Non-Network
Blood	100% after **deductible**	60% after **deductible**
Cardiac Rehabilitation	100% after **deductible**	60% after **deductible**
Chemotherapy	100% after **deductible**	60% after **deductible**
Consultations • Inpatient • Outpatient	 100% after **deductible** 100% after **deductible**	 60% after **deductible** 60% after **deductible**
Contraceptives (All FDA approved devices diaphragms, implants, injections, and IUD's, including patient education and counseling)	100% no **deductible**	Not Covered
Dialysis (will be payable subject to 200% of the Medicare allowable amount)	100% after **deductible**	60% after **deductible**
Fertility Testing, including, medically necessary surgical procedures to correct **infertility**	100% after **deductible**	60% after **deductible**
Home Health Care (120 visits per calendar year)	100% after **deductible**	60% after **deductible**
Hospice	100% after **deductible**	60% after **deductible**
Implants	100% after **deductible**	60% after **deductible**
Injections	100% after **deductible**	60% after **deductible**
Laboratory Testing	100% after **deductible**	60% after **deductible**
Medical Equipment and Supplies	100% after **deductible**	60% after **deductible**
Medical Supplies	100% after **deductible**	60% after **deductible**
Mental Disorders/ Substance Abuse Expenses • Inpatient • Outpatient	 100% after **deductible** 100% after **deductible**	 60% after **deductible** 60% after **deductible**
Occupational Therapy (60 visits in a calendar year)	100% after **deductible**	60% after **deductible**
Office Visits	100% after **deductible**	60% after **deductible**
Orthotics	100% after **deductible**	60% after **deductible**
Physical Therapy (60 visits in a calendar year)	100% after **deductible**	60% after **deductible**
Pregnancy Related Expenses-Mother • Initial visit, Pre-/Post-natal visit • Subsequent Visits	 100% no **deductible** 100% after **deductible**	 60% after **deductible** 60% after **deductible**

	Network	Non-Network
Prescription Drugs		
Annual Prescription Deductible	None	None
Retail		
• Preventive, as required by PPACA	100% after **deductible**	Not Covered
• Generic		
– 30-day supply	100% after **deductible**	Not Covered
– 60-day supply	100% after **deductible**	Not Covered
– 90-day supply	100% after **deductible**	Not Covered
• Formulary/Preferred Brand (co-pay per 30 day supply)	100% after **deductible***	Not Covered
• Non-Formulary/Non-Preferred Brand (co-pay per 30 day supply)	100% after **deductible***	Not Covered
Mail Order (co-pay per 30 day supply)		
• Preventive, as required by PPACA	100% after **deductible**	Not Covered
• Generic	100% after **deductible**	Not Covered
• Formulary/Preferred Brand	100% after **deductible***	Not Covered
• Non-Formulary/Non-Preferred Brand	100% after **deductible***	Not Covered
Specialty Drugs (limited to a 30 day supply and must be purchased from CVS Caremark Specialty Pharmacy)		
• Generic	100% after **deductible**	Not Covered
• Preferred Brand	100% after **deductible***	Not Covered
• Non-Preferred Brand	100% after **deductible***	Not Covered

* If a generic is available but the member requests a brand name drug, the member is responsible for brand co-pay plus any cost differential between brand name and the generic drugs. The difference may apply to the deductible.

	Network	Non-Network
Preventive Care (As described by the United States Preventive Services Task Force (USPSTF))		
• Annual visit, including well baby visit	100% no **deductible**	Not Covered
• Testing	100% no **deductible**	Not Covered
• Bone Density Testing	100% no **deductible**	60% after **deductible**
• Immunizations	100% no **deductible**	Not Covered
• Cancer screenings - Pap smears - Mammogram - PSA	100% no **deductible**	Not Covered
• Colonoscopy	100% no **deductible**	60% after **deductible**
	Please refer to www.uspreventiveservicestaskforce.org for additional information and limitations.	
Preventive Care • Women's Preventive Care - Well woman visits - Screening for gestational diabetes - Human papillomavirus testing - Counseling for sexually transmitted infections - Counseling and screening for human immune deficiency virus - Contraceptive methods and counseling - Breastfeeding support, supplies and counseling - Screening and counseling for interpersonal and domestic violence	100% no **deductible**	Not Covered
	Please refer to www.hrsa.gov/womensguidelines for additional information and limitations.	
Prosthetic Devices	100% after **deductible**	60% after **deductible**
Radiation Therapy	100% after **deductible**	60% after **deductible**
Skilled Nursing Facility (120 days per confinement)	100% after **deductible**	60% after **deductible**

	Network	Non-Network
Speech Therapy (60 visits in a calendar year)	100% after **deductible**	60% after **deductible**
Sterilization • Female employee, spouse/dependent child • Male employee/spouse	100% no **deductible** 100% after **deductible**	Not Covered Not Covered
Substance Abuse Expenses • Inpatient • Outpatient	100% after **deductible** 100% after **deductible**	60% after **deductible** 60% after **deductible**
Transplants	100% after **deductible**	60% after **deductible**
Vision Services	100% after **deductible**	60% after **deductible**
Weight Management	Payment is based on service rendered	Payment is based on service rendered
X-rays	100% after **deductible**	60% after **deductible**
All Other Covered Expenses	100% after **deductible**	60% after **deductible**
MEDICAL EXPENSES – NON - ESSENTIAL BENEFITS		
	Network	**Non-Network**
Alternative Medicine ($1,000 per calendar year) Acupuncture/Acupressure, Therapeutic Massage, Nutrition Therapy, Rolfing, Naturopathy Care	100% after **deductible**	60% after **deductible**
Chiropractic Care ($500 in a calendar year)	100% after **deductible**	60% after **deductible**
Hearing Exam, Testing, Hearing Aids, Implants and Devices $4,500 (combined), once every five years)	100% after **deductible**	60% after **deductible**

NOTE: This is only a brief overview of benefits. Please refer to the following sections of this plan for complete information on the eligibility provisions, limitations and for all other terms of the plan. Any maximums listed are applicable to all plan levels.

OVERVIEW OF BENEFITS: BENEFIT CRITERIA

You need to know that this plan provides coverage for treatment, services, and supplies that meet certain criteria.

For charges to be considered for payment under this plan, the treatment, service, or supply:

- MUST be **medically necessary** (or be preventive),
- MUST be rendered by a covered provider/facility,
- MUST not exceed **reasonable and customary** amounts,
- MUST not be considered **experimental/investigational**, and
- MUST not be limited, restricted, or excluded elsewhere in this **Summary Plan Description (SPD)**.

These criteria, which are explained below, are admittedly very technical. It is not our intention to confuse you. Instead, we would like to assist you with understanding how these provisions relate to your proposed course of treatment. You and/or your **physician** should feel free to contact NGS CoreSource for additional clarification on any of the provisions listed below.

When Is A Procedure, Service, Or Supply Considered Medically Necessary?

A procedure, service, or supply is deemed to be **medically necessary** when it is for the treatment of an **illness** or **injury**; it is prescribed by a **physician** and is professionally accepted as the usual, customary, and effective means of treating a condition. Diagnostic x-rays and laboratory tests that are performed due to definite symptoms of **illness** or **injury** or reveal the need for treatment will be considered **medically necessary**. In the evaluation of medical necessity, the plan may request records that, if legally required to be maintained, must be made available to the plan in order to consider the expenses. The plan may also seek outside medical opinions from appropriate board certified specialists. The plan reserves the right to have the patient examined by an independent specialist in the appropriate field of medicine.

Who Is A Covered Provider?

A provider shall be considered a covered provider if he or she is a provider listed in the definition of "**physician**," "**hospital**," "**skilled nursing facility**," "**hospice**," or "**home health care agency**" (Please see the "Glossary") acting within the scope of his or her license in the state in which they practice. Additionally, the plan will cover other providers who are not **physicians** but who are specifically mentioned as covered providers in this **SPD**, provided they are acting within the scope of their license.

What Is Meant By "Reasonable And Customary?"

"**Reasonable and Customary**" (R&C) refers to certain plan limitations on provider charges, in regard to what will be accepted as allowable under the plan. As the actual purchaser of health care services, you should not hesitate to seek information from medical providers on the cost of proposed treatments for you and your family members, just as you would if you were making any other type of purchase. While the plan has contracted with a Preferred Provider Network (PPO) to pre-arrange negotiated rates with **network providers**, charges over R&C will be denied for **non-network providers** and certain aspects of R&C calculations may also still impact what the plan will reimburse on a network claim. By playing an active role in seeking cost information, you can minimize your own out-of-pocket costs and conserve the dollars applied to any maximums under the plan as well. In general, R&C means that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered. **Reasonable and customary** calculations also use standard methods to adjust for unusual circumstances or complications which may require additional time, skill, or experience.

For non-network services, charges are screened against commercial databases comprised of aggregated data collected from all health plan payers or other normative data derived from sources such as **Medicare** cost to charge ratios, average wholesale price data for prescriptions, and/or manufacturer's retail pricing for certain supplies and devices. If you use a **non-network provider**, you will be responsible for all amounts in excess of R&C and these amounts may be substantial. For non-network professional services (service provided by an individual practitioner), R&C shall mean that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered.

With network professional services (services provided by an individual practitioner), R&C is the fee agreed to by the participating provider as long as your provider adheres to standard billing practices.

All (both network and non-network) health care practitioners must bill the plan using CPT codes to indicate services performed. CPT codes were developed by and are maintained by the American Medical Association (AMA). Along with assigning codes to particular services, the AMA has established guidelines for billing and reimbursement. For example, when more than one surgical procedure is performed in the same operative session, CPT rules limit reimbursement on secondary procedures to 50% of the amount that would normally be reimbursable for that code. This plan's reimbursement will follow CPT guidelines. You should confirm with your provider, whether network or non-network, that his or her practice follows the AMA's CPT coding guidelines to ensure that you do not have a liability for amounts over R&C.

What Is Meant By "Experimental" Or "Investigational?"

The plan will consider a drug, device, supply, treatment, procedure, or service to be "**experimental**" or "**investigational**:"

a. if the drug, device, supply, treatment, procedure, or service cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given for the proposed use at the time the drug, device, supply, treatment, procedure, or service is furnished; or

b. if the drug, device, supply, treatment, procedure, or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure, or service was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if the drug, device, supply, treatment, procedure, or service is the subject of on-going Phase I or Phase II clinical trials, or is in the research and/or **experimental** or **investigational** arm of on-going Phase III clinical trials; or

d. if based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure, or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy.

Exception: An FDA approved drug that meets the criteria set under **reliable scientific evidence** will not be deemed **experimental**.

Requirement For Approved Clinical Trial – Routine Patient Costs

Covered expenses shall include charges for routine patient costs incurred by a qualified individual participating in an approved clinical trial. Services must be rendered by a **network provider**. Routine patient costs do not include:

1. An **investigational** item, device, or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular **diagnosis**.

"Qualified Individual" means a **covered individual** who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition and either;

1. The referring **health care professional** is a participating health care provider and has concluded that the **covered individual's** participation in such trial would be appropriate; or,
2. The **covered individual** provides medical and scientific information establishing that the **covered individual's** participation in such trial would be appropriate.

What Is Excluded Under The Plan?

The plan excludes payment for certain treatment, services, or supplies in the form of limitations or maximums. When determining if a particular treatment, service, or supply is payable, it is important to first consider the criteria listed above, then review the “Benefit Details,” “Disease Specific Treatments,” “Supplementary Services and Supplies,” and “What Is Not Covered?” sections to determine if any limitations, maximums, or exclusions apply.

PREVENTION AND HEALTH MANAGEMENT

"An ounce of prevention is worth a pound of cure." Making preventive care a priority in your life can be difficult, but it is always worthwhile. Many of today's most debilitating health conditions such as heart disease, cancer, diabetes and chronic respiratory disease may be directly linked to lifestyle choices including tobacco use, physical inactivity, poor nutrition, and excessive alcohol consumption. The solution seems simple…adopt a healthy lifestyle and avoid preventable health conditions…but changing our daily behaviors can be extremely difficult. Gunnison County, Colorado's health plan has been designed to support you and your family each step of the way as you make wellness a central part of your lives.

How Will I Know If My Care Is "Preventive Care?"

Many people are confused about when their care is considered "preventive" and when their care is considered "diagnostic." While each situation is different, a general rule of thumb is treatment for *personal* history or symptoms will be considered "diagnostic" care or treatment. Treatment for *family* history or symptoms is considered "preventive" care or treatment.

Who Needs Wellness?...You Do!

Wellness is important for every person, at every age and of every health status, but our specific needs are very different. For that reason, the Gunnison County, Colorado's preventive care benefit offers you flexibility - you and your **physician** determine what services are best for you. The plan, in conjunction with other preventive programs, also offers you guidance - to help you manage your health and use your benefits wisely.

What Is Covered?

This plan provides the following preventive benefits for you and your covered **dependents**:

- **Required preventive care** as recommended by the United States Preventive Services Task Force (USPSTF) with an A or B rating, including but not limited to:
  - Immunizations
  - Well child care
  - Routine physical exams
  - Screening for high blood pressure
  - Mammogram
  - Screening for cervical cancer
  - Screening for cholesterol
  - Screening for diabetes
  - Screening for colorectal cancer, including colonoscopies and sigmoidoscopies

NOTE: As the USPSTF recommendations may change periodically, please go to the website www.uspreventiveservicestaskforce.org for full coverage information.

- Prostate Specific Antigen (PSA) exam and related testing
- Women's preventive services under the Health and Human Services Health Resources and Services Administration (HRSA) including but not limited to:
  - Well woman visits
  - Human papillomavirus testing
  - Counseling for sexually transmitted infections
  - Counseling and screening for human immune deficiency virus
  - Breast feeding supplies, support, and counseling
  - Screening and counseling for interpersonal and domestic violence
  - Screening for gestational diabetes
  - Contraceptives (Includes all FDA approved devices, diaphragms, implants, and IUD's, including patient education and counseling. Refer to the section titled "What If I Need a Prescription Medication?" for benefits for contraceptive pills, injections, topical patches and emergency contraceptives.)

NOTE: As the HRSA recommendations may change periodically, please go to the website www.hrsa.gov/womensguidelines/ for full coverage information.

NETWORK ACCESS

Why Is Having A "Family" Physician Important?

Managing your family's healthcare, from both a medical and financial perspective, can be a difficult and complicated process. Your family **physician** is your partner in navigating that process. He or she coordinates the care your family receives as well as the providers that render that care. Seeing your family **physician** regularly keeps him or her well informed about your health and allows you and your **physician**, together, to make the best possible choices about the treatment your family receives, regardless of plan coverage.

What Is A Network Provider?

A **network provider** is a facility or practitioner who has a signed contract with a preferred provider network (PPO) to provide medical services at a specific rate or pay. **Network providers** are independent contractors and the plan does not provide any guarantee concerning the care provided by **network providers**.

How Do I Locate Network Providers In My Area?

To locate **network providers** in your area, simply log onto the NGS CoreSource website (www.ngscoresource.com) and click on "My Links," then choose an option under "Find a Provider." You may search for a provider by specialty, location or distance. You may also contact NGS CoreSource at (800) 521-1555.

How Will Benefits Be Paid?

If:	Then:
You or your **dependent** need **emergency** treatment and receive treatment at a non-network facility	Benefits will be paid at the network level.
You or your **dependent** utilize a **non-network provider** and such specialty provider and/or service is not available through a **network provider**	Benefits (including any related laboratory tests, x-rays or follow-up visits by the same **non-network provider**) will be paid at the network level.
You or your **dependent** utilize a **non-network provider** in a non-**emergency** situation because a **network provider** refers you or your covered **dependent** to a **non-network provider** or if you or your **dependent(s)** choose to seek the services of a **non-network provider** and such specialty provider and/or service is available through a **network provider**	Benefits (including any related laboratory tests, x-rays or follow-up visits by the same **non-network provider**) will be paid at the Non-Network level. You may wish to have the **non-network provider** covered at the in-network level. A **non-network provider** must meet criteria established by the plan in order to be approved for coverage at the in-network level. Contact the Gunnison County Human Resources Department for a copy of the "Guidelines for covering **non-network providers** at the In-Network Level". In order to have a **non-network provider** covered at the in-network level, you or your **dependent** must have the provider approved by the Gunnison County Human Resources Department prior to any services being rendered. Contact the Gunnison County Human Resources Department at (970) 641-7623 or 200 E. Virginia Ave., Gunnison, CO 81230 to make such a request.
You or your **dependent** utilize a network facility for **inpatient/outpatient** services/ procedures, but the network facility uses a **non-network provider** for anesthesia, the interpretation of laboratory tests and x-rays and other **medically necessary** services	Benefits will be paid at the network level.
You or your **dependent** are admitted to a non-network **hospital** through the **emergency** room because of **emergency**	Benefits will be paid at the network level until the attending **physician** determines that transfer to a network **hospital** is medically feasible. If you or your covered **dependent** choose to stay in the non-network facility, the plan will then pay benefits at the non-network level.

Foreign Claims

You or your **dependent** may be traveling, attending school, working for the **company** and residing outside the United States (U.S.), or working in the U.S. and a citizen of another country. Under these circumstances, you or your **dependents** may receive medical treatment in another country and it is important for you to understand how this plan will treat expenses incurred in a country outside of the U.S.

1. If you and/or your **dependent** are a citizen of another country covered under the national health program of your country of origin, any treatment that you receive within your country of origin will be covered by the national health plan and not covered by this plan. Covered expenses for treatment that you, or your **dependent**, receive in the U.S. will be covered under this plan. If you and/or your **dependent** reside in another country (not your country of origin) in order to perform work for the **company** or for your **dependent** to attend a qualified institute of higher learning, covered expenses for treatment received in the country of residence will be covered under this plan as though they were incurred in the U.S. If you and/or your **dependent** are traveling outside of the U.S., your country of residence or your country of origin, only covered expenses for **emergency** treatment will be considered for reimbursement under the plan.

2. If you and/or your **dependent** is a U.S. citizen residing outside of the U.S. in order to perform work for the **company** or for your **dependent** to attend a qualified institute of higher learning, covered expenses for treatment that you or your **dependent** receive in the U.S. or the country of residence will be covered under this plan. If you, or your **dependent**, are traveling outside of the U.S. or your country of residence, only covered expenses for **emergency** treatment will be considered for reimbursement under the plan.

3. If your **dependent** child's residence is different than yours (e.g., **dependent** children living with a former **spouse**), the plan will consider only the following expenses for reimbursement:
   - Covered expenses incurred within the U.S.
   - Covered expenses incurred within the country of origin only if no national health plan is available to the **dependent**.
   - Covered expenses incurred outside the U.S. in the country of residence (but not country of origin).
   - Covered expenses for **emergency** treatment only while traveling outside of the U.S., the country of origin, or the country of residence.

4. If you and/or your **dependent** is a U.S. citizen, residing in the U.S. and you incur medical expenses in another country, **emergency** treatment will be considered as though the expense was incurred in the U.S. Non-**emergency** treatment or elective services outside of the U.S. will not be covered under this plan.

PLAN STRUCTURE

What Is The Plan Deductible?

The **deductible** is the specific dollar amount that you must pay (or "satisfy") before the plan pays its share of covered charges each calendar year. The **deductible** is satisfied on a calendar year basis with expenses from January through December. For **deductible** amount(s) and other specific benefit information, please refer to the section titled "Overview of Benefits."

Your **deductible** varies based on whether you choose to receive services from a **network** or **non-network provider**. When you enroll in the plan with individual coverage, your individual **deductible** will apply. However, when you enroll with family coverage, your family **deductible** will apply. Eligible expenses, including **prescription drugs**, for all family members contribute to the **deductible**. When the family, calendar year **deductible** is met by any combination of family members, the plan pays subsequent eligible expenses (including **prescription drugs**) for the entire family.

Expenses applied toward the Network **deductible** will not be applied to the Non-Network **deductible**, and expenses applied to the Non-Network **deductible** will not be applied to the Network **deductible**.

What Is Your Out-Of-Pocket Maximum?

This plan shares with you the expense for certain services. Your co-payment is the balance that you must pay of the **reasonable and customary** charge for covered benefits including **prescription drug**s, when payment is made at less than 100%.

This plan is designed to limit your out-of-pocket expense. The **out-of-pocket maximum** limits are for covered services rendered during each calendar year. Your **out-of-pocket maximum** varies based on the plan option you have elected and whether you choose to receive services from a **network** or **non-network provider**. For **out-of-pocket maximum** amount(s) and other specific benefit information, refer to the section titled "Overview of Benefits."

Expenses applied toward the Non-Network out-of-pocket will not be used to satisfy the Network **out-of-pocket maximum** and expenses applied to the Network **out-of-pocket maximum** will not be applied to the Non-Network out-of-pocket.

The individual **out-of-pocket maximum** will apply to each family member and will also apply to the family **out-of-pocket maximum**. Once the family **out-of-pocket maximum** has been satisfied the **out-of-pocket maximum** will be considered satisfied for all family members for the calendar year. Any number of family members may help to meet the family **out-of-pocket maximum** amount, but no more than the individual **out-of-pocket maximum** for any one **covered individual** will apply toward the family **out-of-pocket maximum** expense limit.

For services rendered during the remainder of the calendar year after a **covered individual** reaches their **out-of-pocket maximum** limit, this plan will pay 100% of the **reasonable and customary** charges for subsequent expenses which would otherwise be paid at a percentage other than 100%.

Expenses that cannot be used to satisfy the **out-of-pocket maximum** limit and not eligible for 100% payments even if the **out-of-pocket maximum** is met are:

- Plan penalties

Why Do I Get So Many Bills?

This is possibly the most frequently asked question by those who receive medical services. Generally, many different health care providers work together to ensure that the highest possible level of care is provided.

You may receive bills from providers who are contracted by the **hospital**, such as anesthesiologists, residents or pathologists. Additionally, you may receive bills from providers who your **physician** asked to participate in your care, such as specialists who provide consultations. Finally, you will receive bills from the facility in which the services were performed, such as the **hospital** or surgical center.

You should review all of your bills. If you see a charge for a provider or service you do not remember, you should ask to review your records to verify that the service was provided.

Does This Plan Have A Pre-Verification Provision?

Your plan includes a feature called "pre-verification of benefits." Pre-verification is the process of evaluating whether proposed services, supplies or treatments meet the medical necessity and other provisions of the plan to help ensure quality, cost effective care.

The intent of the pre-verification process is not to limit the patient's choice of a provider, nor to tell the patient and the provider what treatment or services should be performed. The provider and patient may proceed with any treatment plan they may choose, regardless of the benefit determination under the pre-verification process, recognizing that the patient will be responsible for the additional cost incurred beyond the plan benefit.

Do I Need To Get A Pre-Verification?

This plan requires all non-emergent **inpatient** admissions to be reviewed prior to your scheduled admission date. "**Inpatient** admissions" include **inpatient hospital** admissions, partial hospitalization, **hospice**, transplants and home health care. This provision does not apply to childbirth admissions less than 48 hours for vaginal delivery or 96 hours for cesarean delivery, nor does it apply to services rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession. Please note that if you or your **dependent** need medical care that would be considered urgent care or **emergency services**, then there is no requirement that the plan be contacted for prior approval.

To verify your admission, you or your provider may call: (800) 521-1555.

Please note that this plan does not reduce any available benefits if you fail to obtain pre-verification.

How Does The Pre-Verification Process Work?

There are different types of verifications that may be performed in connection with your treatment. Your specific circumstances will help determine which verification method is appropriate for your situation.

The following information should be provided when you or your provider request verification:

1. Your name, address, phone number, and identification number;
2. Your employer's name;
3. If you are not the patient, the patient's name, phone number, and address.
4. The admitting **physician's** name and phone number;
5. The name of the **hospital** or facility;
6. Date of admission or proposed admission; and
7. The condition for which the patient is being admitted to the **hospital** or facility.

Pre-Verification Before Services Are Rendered - Urgent Care Pre-Service Claims

If an urgent care **pre-service claim** is filed following the proper claims filing procedures, and no additional information is needed, the **Claims Administrator** will notify the **claimant** of a decision within 72 hours.

If additional information is needed the **Claims Administrator** will notify the **claimant** within 24 hours. The **claimant** will have up to 48 hours from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 48 hours after the request for information.

When proper claims filing procedures are not followed, the **Claims Administrator** must notify the **claimant**, orally or in writing, within 72 hours of receipt of the claim. The **COBRA** must respond to that notification within 72 hours. If the **claimant** does not properly file the claim within 72 hours, the claim will be denied. If the **claimant** properly files the claim within 72 hours, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours of receipt of the properly filed claim.

Please note that if you or your **dependent** need medical care that would be considered urgent care or **emergency services**, then there is no requirement that the plan be contacted for prior approval.

Pre-Verification Before Services Are Rendered - Non-Urgent Care Claims

If a request for a non-urgent care pre-verification is made providing the complete information described above, the necessary clinical information will be requested from the provider and the requesting person will be notified of the pre-verification determination within 15 days of receipt of the clinical information.

If all of the information listed above is not provided, the requesting person will be notified, orally or in writing, within five days of receipt of the request. You or your provider must respond to that notification providing the information above within 15 days. If there is no response from you or your provider within these 15 days, the plan will deny the pre-verification. If further clinical information is needed, or there are matters that prevent a decision and they are beyond the control of the plan, the requesting person will be notified within 15 days. You or your provider will have up to 45 days from the request to supply the needed information. When the information is received, the requesting person will be notified of a determination within 15 days from the receipt of the response. If there is no response from you or your provider to the request for information, the pre-verification will be denied within 60 days after the request for information. Should the required information be submitted subsequently, it will be considered a new request and will be reviewed in accordance with the above guidelines.

Verification During Your Hospital Stay

If a late notification of an admission is received and your care is already ongoing, or you stay in the **hospital** longer than originally verified, what is referred to as "concurrent review" will be performed. So, while you are in the **hospital**, your treatment may continue to be reviewed to verify additional days of **hospital confinement**, other necessary treatment or discharge planning.

When a concurrent review is performed on an urgent request, the requesting person will be notified of a determination within 24 hours from receipt of the request, as long as the request was made at least 24 hours before the end of the last verified day.

If the request was made less than 24 hours prior to the end of the last verified day, and all necessary clinical information was provided, then the requesting person will be notified of a determination within 72 hours from receipt of the request. If additional information is needed, the process described under "Pre-Verification Before Services are Rendered – Non-Urgent Care Claims" will be followed.

When a concurrent review is performed on a non-urgent request, the requesting person will be notified of the verification determination as quickly as possible, but not later than 15 days from receipt of the request. If additional information is needed, the process described under "Pre-Verification Before Services are Rendered – Non-Urgent Care Claims" will be followed.

Should the verification determine that the plan's medical necessity provision will only allow a reduced **hospital** stay or shortened course of treatment before the end of any previously verified period, then you and your provider will be notified of the proposed change and you or your provider may appeal the change in the pre-verification determination. The decision on the appeal must be provided prior to the end of the previously verified period.

Finally, if at the end of a previously verified **hospital** stay it is determined that continued **hospital confinement** no longer meets the medically necessity provision of the plan, additional days will not be verified.

Verification After A Hospital Stay

When you or your provider do not obtain verification prior to receiving services, or if you are discharged from the **hospital** during the time between the request for verification and the receipt of necessary clinical information, a verification process called "retrospective review" will be completed.

When a retrospective review is performed, the requesting person will be notified of a decision as quickly as possible, but no later than 30 calendar days from receipt of the request.

If additional information is needed, you or your provider will be notified within 30 days. You will have up to 45 days from the request to supply the needed information. When the information is received, the requesting person will be notified of the retrospective review determination within 15 days from the receipt of the response. If you, or your provider, do not respond to the request for information, the plan will deny the retrospective review within 60 days after the request for information. Should the required information be submitted subsequently, it will be considered a new request and will be reviewed under the above guidelines.

What If My Provider And I Disagree With The Decision?

If you, or your provider, disagree with the verification decision, you have a couple of options. You and your provider may proceed with any treatment plan you may choose, regardless of the benefit determination or you may be able to request reconsideration.

If an initial determination is made that the proposed treatment does not meet the medical necessity provision of the plan and no "peer-to-peer" conversation has taken place between your attending **physician** and the independent reviewing **physician** who participated in the original determination, then the reconsideration process will be offered.

If your provider requests reconsideration within two business days of the adverse determination and peer-to peer conversation has not occurred, a peer-to-peer conversation between your attending **physician** and the original independent reviewing **physician** (or an alternate **physician** with the same qualifications if the original reviewing **physician** is unavailable) will be arranged. The requesting provider will be notified of the peer-to-peer conversation decision within one business day. If the services cannot be approved after the peer-to-peer conversation, a formal letter will be issued detailing the reasons for the decision.

Case Management

The plan provides a **covered individual** the opportunity to receive medical case management services.

Medical case management is a program that manages the provision of healthcare to individuals with high cost medical conditions. The goal is to perform assessment, planning, facilitation, and advocacy for options and services available to meet an individual's health needs. This process is performed through communication and coordination of available resources to promote quality cost-effective outcomes.

When it is determined that a case would benefit from case management, arrangements will be made for case review by a **nurse** coordinator from an independent case management firm. The **nurse** coordinator will 1) contact the individual (and family) to assist with the individual's needs for coverage and benefit information, 2) coordinate the services with health care providers, 3) perform various services associated with a discharge or return home, 4) provide patient education, and 5) make recommendations to the patient (family) concerning the types of services that can aid in the recovery process.

When the patient chooses to follow the recommendations made through case management, the plan may, at its discretion, cover additional **medically necessary**, non-experimental expenses.

BENEFIT DETAILS

Working With Your Physician

You and your **physician** are a team and your goal is to make sure you are in the best health possible. Both you and your **physician** have important responsibilities in helping the team reach its goal. You can work better with your **physician** by following three simple steps:

1. Ask
    - Ask questions, especially if you do not understand your **physician's** or **nurse's** instruction.
    - Let your **physicians** and **nurses** know if you need more time to ask questions about your health.

2. Tell
    - Tell your **physician** your health history. Be sure to mention family history of diseases and conditions.
    - Tell your **physician** about your health now. Only you know how you feel and whether you feel differently than you did before.
    - Be sure to tell your **physicians** and **nurses** if you have any allergies or reactions to medicines.

3. Follow up
    - Once you leave the **physician's** office, follow up.
        i. If you have questions, call the **physician's** office.
        ii. If you have problems with your medicine, call your **physician** or your pharmacist.
        iii. If you need to see a specialist or get a test, make the appointment or ask your **physician's** office to make the appointment.
        iv. If you do not hear from your **physician** or **nurse** about test results, call and ask. If you do not understand the results, ask what they mean.

What If I Need Diagnostic Testing?

There are numerous reasons why you may need diagnostic testing. Diagnostic testing provides information needed to help your **physician** diagnose your condition, as well as prescribe, refer and monitor treatment of your condition.

Some diagnostic tests are invasive and require a perforation or incision into the skin or a body cavity to obtain a specimen (e.g., biopsy or catheterization). Other diagnostic tests are non-invasive (e.g., urine test, x-rays, CAT/MRI scans, etc.) This section addresses non-invasive diagnostic tests. See "What if I Need **Surgery**?" for more information regarding invasive tests.

The plan will pay for the diagnostic tests, including any charges associated with interpreting the results.

Preparing For Diagnostic Testing

If your **physician** orders diagnostic testing, you may want to ask your **physician** the following questions:

1. Why do I need the testing?
2. What do I need to do to prepare for the testing (e.g., diet, fasting, etc.)?
3. Should I take my medications/supplements before my testing?
4. Will the testing be painful or uncomfortable?
5. Who do I call to obtain my results?
6. How long will it take to receive my results?
7. What are the "normal" ranges of the testing?
8. If all my test results are normal, does that mean I have nothing to worry about?

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- Allergy tests.
- Laboratory testing, x-rays, and other diagnostic testing (e.g., CAT/MRI scans, EKGs, EMGs, EEGs, thyroid testing, nerve conduction studies, pulmonary function studies, etc.) to diagnose an **injury** or **illness** (including charges associated with interpreting the results), when ordered by a **physician** and performed in a:
  - **hospital outpatient** department;
  - **hospital emergency** room to initially care for or an **emergency**;
  - **hospital emergency** room when related to a condition that does not qualify as an **emergency**;
  - **physician's** office; or
  - laboratory or x-ray facility.
- Pre-admission tests performed in a **hospital outpatient** department, a **physician's** office, or separate laboratory or x-ray facility before a covered **hospital confinement** or **surgery**.
- Testing - lab test and x-rays to determine the cause of **infertility**.
- X-rays (including the interpretation of the results) related and performed prior to a covered oral surgical procedure.
- Genetic testing when **medically necessary** to establish a **diagnosis** of an inheritable disease if the patient has clinical symptoms or is at direct risk of inheriting the disease and the results of genetic testing will directly impact the patient's treatment and all other means of determining a definitive **diagnosis** have been exhausted. Genetic counseling unrelated to pregnancy will be covered when necessary in accordance with the American College of Medical Genetics.

What If I Need Emergency Treatment?

Seeking medical care during an **emergency**, or in a situation which might be an **emergency**, may be a confusing time. If you are in a situation that might require immediate care, you should receive medical treatment as quickly as possible.

Be Prepared For A Possible Emergency

During an **emergency** you will need to act quickly. However, there are some things that you can do, in advance, to ensure that you receive the best care possible. Taking just a few minutes to prepare for a possible **emergency** can be beneficial in the long run.

1. Know the location of the closest **emergency** room.
2. Make sure all your family members know what to do in the case of an **emergency**.
3. Prominently display **emergency** contact information, including ambulance, fire and **physician's** numbers.
4. Keep a Personal Health History for each member of your family. Keep this history in your purse or wallet so you can bring it with you in the case of an **emergency**. This history will assist the **emergency physicians** with providing the best possible treatment and should include the following information.
    - I was in the **hospital** for (list conditions and dates):
    - I have had these **surgeries**:
    - I have had these **injuries**/conditions/**illnesses**:
    - I have these allergies (list type of allergy and reaction):
    - I have had these immunizations (shots):
    - I take these medicines/supplements (bring with you, if possible):
    - My family members (parents, brothers, sisters, grandparents) have/had these major conditions:
    - I see these other health care providers (include the name and phone number for each provider, as well as why you see them):

Urgent Or Emergency Care Centers

What if you get sick at night, on a holiday, or over the weekend? You cannot get to your **physician**, but you are not sick enough to go to the **emergency** room. There may be an "urgent" or "**emergency**" care center near you. These centers are open long hours every day to handle problems that are not life-threatening. But they are no substitute for a regular primary care **physician**.

To make sure an urgent or **emergency** care center provides quality care, call or visit the center to find out:

1. If the center is licensed. Then check to see if it is accredited by a group such as The Joint Commission (telephone: 630-792-5800; website: http://www.jointcommission.org) or the Accreditation Association for Ambulatory Healthcare (telephone: 847-853-6060; website: http://www.aaahc.org). The accreditation certificate should be posted in the facility.
2. How well trained and experienced are the center's **health care professionals**?
3. If the center is affiliated with a **hospital**. If it is not, find out how the center will handle any **emergency** that could happen during your visit.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- The plan pays benefits for professional ambulance services (ground, sea, or air) for transportation to treat an **emergency**. Covered transportation will be to the closest facility equipped to handle the condition. The plan also covers ambulance transportation to a **skilled nursing facility** or between **hospitals** when a patient needs immediate testing, or when other treatments cannot be performed by the **hospital** in which the patient is confined. Transportation from the **hospital** to the patient's home is covered, if a home health care program is in place.
- The plan pays benefits for a **hospital emergency** room, including **physician** and covered facility charges to initially treat an **emergency** or a medical condition which requires immediate care or for immediate care of a chronic condition.
- The plan pays benefits for **physician** and facility charges for treatment received at an urgent or **emergency** care center.

What If I Need To Be Admitted To The Hospital?

When you need to be admitted to the **hospital**, it can be a stressful time for you and your family. But, it is important to remember to ask your **physician** a few questions before you are admitted.

1. Why do I need to be treated in the **hospital**? Are there any treatment alternatives?
2. What procedures are you performing and what are the possible complications?
3. How long will I be in the **hospital**?
4. What is the expected recovery period following my discharge?
5. How will any pain I experience be controlled or managed?
6. Will I require follow-up care with you or another **physician** after I am discharged?
7. What is my prognosis and what changes do I need to make?
8. Is the facility in my network?
9. Have you called to verify the benefits available through my health plan?

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- **Inpatient** room and board charges, up to the **hospital's** semi-private room rate. Charges made by a **hospital** having only single or private rooms will be considered at the least expensive rate for a single or private room.
- **Inpatient** room and board charges for specialty care units (ICU, CCU, Burn Unit, etc.).
- Laboratory tests, x-rays, and other diagnostic testing performed during the **hospital** stay, as well as the interpretation of the results.
- Consultations provided by a **physician** during your confinement.
- **Physicians'** visits, up to one visit per day (unless visits are by different **physicians** and for different diagnoses).
- Certain services, supplies and treatment provided in the **hospital** during your confinement, including, but not limited to:
  - use of operating, delivery, recovery and treatment rooms;
  - laboratory and x-ray services;
  - anesthesia and its administration;
  - use of incubators, oxygen and dialysis machines;
  - **physical therapy**,
  - chemotherapy and radiation therapy;
  - drugs and medicines consumed on the premises; and
  - dressings, supplies and casts.

What If I Need Step Down Care?

After an **inpatient** stay or after **surgery** it may be appropriate to complete your recovery in a facility that specializes in providing restorative and rehabilitative care, rather than acute care. To receive this care, you may be admitted to another facility or transferred to another floor or wing of the same facility. In other cases, treatment may be able to be provided in your home. Charges will be covered as described below and will be payable as described in the section titled "Overview of Benefits."

Rehabilitative Or Skilled Nursing Facility Care

Services of a facility licensed as a rehabilitation facility or **skilled nursing facility** can benefit patients with a range of medical needs, from long-term 24-hour nursing care to short-term rehabilitation. A broad range of services are available to address the patient's advanced medical, social and personal care needs. Services are typically, although not necessarily, provided after an **inpatient** stay or **surgery**.

NOTE: Admissions must begin within 14 days following a **hospital confinement** of at least 3 days and be for the same or related cause as the prior **hospital confinement**.

What Is Covered?

This plan will cover the level of care appropriate for your condition. Rehabilitative and **skilled nursing facility** care benefits include:

- Room and board, not to exceed the semiprivate room rate. Charges made by a facility having only single or private rooms will be considered at the least expensive rate for a single or private room. Charges for private rooms will not be limited to the semi-private room rate when the private room is **medically necessary**.
- Other **inpatient hospital** services even though rendered by a rehabilitation or **skilled nursing facility**.
- **Physical therapy**.
- Speech therapy where speech is impaired due to **illness** or **injury**.
- Occupational therapy to restore function lost due to **illness** or **injury** by an **occupational therapist**.
- Follow up for a covered service.
- **Prescription drugs** dispensed by a rehabilitation or **skilled nursing facility**.

Home Health Care

Home health care services can often offer patients increased levels of comfort and security by allowing them to be treated by **health care professionals** in their own home environment rather than in a **hospital**. When those services meet the following criteria, this plan provides for services of a **home health care agency** that is **Medicare**-approved and licensed in the state in which it is located:

1. Services are under the direction of a **physician** who provides and regularly reviews a written treatment plan.
2. Services conform to the **physician's** written treatment plan outlining the patient's **diagnosis**, prognosis and medical needs or to avoid placing the patient at risk for serious medical complications; and
3. Services are provided by a licensed **nurse**, therapist, or home health aide who is an **employee** of the **home health care agency**.
4. Services are intermittent or hourly in nature,
5. The services are provided in lieu of a continued hospitalization, confinement in a **skilled nursing facility**, or receiving **outpatient** services outside of the home,
6. The member is homebound because of **illness** or **injury** (i.e., the member leaves home only with considerable and taxing effort and absences from home are infrequent, or of short duration, or to receive medical care), and
7. The nursing services provided are not primarily for the comfort or convenience of the patient.

What Is Covered?

The following benefits are available through this plan to assist a patient requiring health services in his or her home:

- Part-time or intermittent nursing care.
- Part-time or intermittent home health aide services (caring for the patient) by an aide.
- **Physical therapy**, occupational therapy, and/or speech therapy.
- Infusion therapy, provided by a **home health care agency** or a licensed home infusion company.
- Other covered services billed by a **home health care agency**.

Hospice Care

Facing the necessity of end of life care for yourself or a loved one is especially difficult. **Hospice** care services help to ensure that the dying person's last days are filled with comfort and dignity.

What Is Covered?

The following benefits are available through this plan to assist both the dying person and his or her caregiver:

- Room, board and other services and supplies for **inpatient hospice** care.
- **Outpatient hospice** charges.
- Part-time or intermittent nursing care rendered by a **health care professional**.
- Speech, physical or respiratory therapy.
- Part-time or intermittent home health aide services by an **employee** of the **hospice**.
- Medical supplies prescribed by a **physician** and supplied by the **hospice**.
- Drugs and medicine supplied by the **hospice**.
- Respite care, up to 5 consecutive days per month.

What If I Am Going To Have A Baby?

Congratulations on the upcoming birth of your child! When you learn of your pregnancy, it is often a very emotional time for you and your loved ones. Once you get over the initial excitement, it is very important that you start making decisions about your pre-natal care and the **physicians** who will help you bring your child into this world.

How To Improve The Quality Of Your Pregnancy And Your Baby's Health

The first step toward improving the quality of your pregnancy and your baby's health is to seek good pre-natal care, which includes the following:

1. Good nutrition and healthy eating habits including a well-balanced diet.
2. Frequent pre-natal office visits with your **physician**.
3. Routine testing, including ultrasounds, blood screenings, and other necessary tests as determined by your **physician**.
4. Following the advice of your **physician**.
5. Calling your **physician** whenever you are experiencing a symptom that you think may be a danger sign.

The next step is choosing the right **physician** for you. It is important to ensure that the **physician** you select will provide pre-natal care, as well as delivery and post-natal services. And make sure that you find a **physician** who you feel comfortable with, so that you feel okay asking questions.

What Is Covered? - Mother's Expenses

This plan provides coverage for certain medical expenses associated with maternity care for the **employee**, **spouse** and/or **dependent** children. The plan will also cover certain expenses for a covered female **dependent** as specified under Women's Preventive Care. (Refer to www.hrsa.gov/womensguidelines/ for additional information and limitations.) The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- **Physician's** charges associated with pre-natal and post-natal care, including routine testing and ultrasounds.
- Amniocentesis when **medically necessary** to determine the condition of the fetus.
- **Inpatient** covered **hospital** services related to your pregnancy and delivery.
- Birthing center charges for both **hospital** on-site and freestanding centers.
- **Physician's** charges associated with delivery services (including **surgery** and related anesthesia).
- Surgical assistance provided by a physician's assistant or another **physician**, when **medically necessary** and ordered by the attending **physician**.
- Fetal **surgery** and related charges for non-experimental procedures performed to enhance or protect the outcome of the pregnancy.

- Genetic testing when **medically necessary** to establish a **diagnosis** of an inheritable disease if the patient has clinical symptoms or is at direct risk of inheriting the disease and the results of genetic testing will directly impact the patient's treatment and all other means of determining a definitive **diagnosis** have been exhausted. Genetic counseling in connection with pregnancy will be covered if:
  - the parents had a previous child born with a genetic disorder, birth defect, chromosome abnormality, mental retardation, autism, developmental delay or **learning disability**, or
  - the pregnancy is known to be at increased risk for complications or birth defects based on ultrasounds, screening tests, ethnicity, maternal age, exposure to external agents, known genetic disorder affecting either parent, previous stillbirths or repeat miscarriages and a suspicion of chromosome abnormalities, or closely related couples.

What Is Covered? - Newborn's Expenses

As long as you or your **covered spouse** enrolls your eligible newborn within 30 days following his or her birth, the plan pays benefits for the following services (even if the plan does not cover the mother's expenses). The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- Your covered newborn's **inpatient** covered **hospital** services.
- Initial examination by a **physician** other than the delivering **physician**.
- Routine nursery visits (up to one visit each day for each **diagnosis**) during the newborn's **hospital** stay.
- Consultations provided by a specialist.
- **Physician's** charges associated with circumcision.

You Should Know

The provisions of this plan are intended to comply with a federal law prohibiting all group health plans from restricting the length of the **hospital** stay to less than 48 hours following vaginal delivery and less than 96 hours following a cesarean section. In addition, the plan does not require any prior authorization for **hospital** stays less than 48 hours (or 96 hours as applicable). After consulting with you, your attending **physician** can still elect to discharge you and/or your baby earlier than 48 hours (or 96 hours as applicable) following delivery.

DISEASE SPECIFIC TREATMENTS

Complex medical conditions require complex treatments to help patients manage their diseases. Though the treatments can be extremely difficult, often they can help patient's live full, active lives. If you or a family member is facing the need for an invasive treatment, you are likely also coping with stress and anxiety, decisions about treatment options, and the need for support.

What If I Need Chemotherapy?

Though cancer and its treatments come in many forms and varieties, chemotherapy, also known as cytotoxic therapy, is one of the more common ways to fight the disease.

Biologics Oncology Drug Benefit Program

This provision describes a special medical management program designed for certain aspects of care received by cancer patients.

Your plan has entered into an arrangement with Biologics, a company specializing in oncology management, to assist you and your oncologist during the course of cancer treatment when administered either in an **outpatient** setting (e.g. in the **physician's** office or other covered **outpatient** setting) or an **inpatient** setting. The program applies to the chemotherapy plan of treatment and other oncology pharmaceuticals to be used in connection with your cancer treatment.

In order to initiate these oncology management services, your oncologist should contact NGS Coresource at 1-800-521-1555 to verify plan benefits. At that time, your oncologist will be asked to contact Biologics and to provide to your assigned Biologics' Oncology Nurse Specialist (ONS) a copy of the treatment plan that your oncologist has prescribed for you. Once the oncologist has contacted Biologics, your assigned ONS will contact you periodically to provide support, education, and answer any questions you might have about your disease and your treatment plan. Your assigned Oncology Nurse Specialist will remain in contact with you and your oncologist for the duration of your chemotherapy treatment plan. In addition, clinical oncology pharmacists will be available to you and your oncologist on a 24/7 basis by contacting 1-800-983-1590. You will be encouraged to call this number if you have questions regarding the cancer drugs being used to treat your cancer, related side effects and other quality of life issues.

If your oncologist determines that oral anti-cancer drugs and/or supportive medications should be taken in your home following the **inpatient** or **outpatient** chemotherapy, your oncologist should contact Biologics and those drugs will be sent directly to your home address or another location if you prefer, in time to meet the medication schedule specified by your oncologist. A clinical oncology pharmacist will call you to discuss the medications and answer any questions you may have about the specific drugs you are taking at home.

Unless the treating oncologist has entered into an agreement with Biologics to accept other reimbursement rates, the payment for all covered expenses for drugs used in the treatment of cancer shall be paid at the rate of Average Sales Price (ASP) plus 10%.

Average Sales Price (ASP) means the average sales price, updated quarterly by **Medicare** under the Medicare Part B drug payment system.

In order to receive benefit payments under the plan, your oncologist's chemotherapy plan of treatment must be received by Biologics, and deemed not to be **experimental** and/or **investigational**. If any of the drugs prescribed by your oncologist requires specific pathology results or molecular marker results to validate their use, these results must be provided to Biologics prior to validation of your treatment regimen.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits":

- Injectable chemicals and their administration.

What If I Need Dialysis?

Dialysis is the most common method to treat advanced and permanent kidney failure. During the waiting period for **Medicare** benefits, this plan provides benefits for dialysis due to chronic renal failure as described below and will be payable as described in the section titled "Overview of Benefits."

Renal Dialysis Services. Renal dialysis visits, are paid at 200% of the **Medicare** equivalent rate, up to the out-of-pocket limitation after the satisfaction of deductible, if any, of the allowable amount. For renal dialysis treatments associated with an in-patient hospitalization, the **Plan Administrator** has the discretionary authority to negotiate a contract rate or other discounting arrangement on the entire inpatient claim.

Medicare Part B Reimbursement

If the Covered Person has End-Stage Renal Disease ("ESRD"), the Plan's primary status applies during the first thirty (30) months of dialysis, the first thirty (30) months of treatment in connection with a transplant, or as otherwise directed by Centers of Medicare and Medicaid Services ("CMS") /**Medicare** coordination rules for ESRD. Thereafter, **Medicare** generally becomes the primary payer of benefits.

The **Medicare** Secondary Payer statute requires the Plan to identify members in the Plan, including eligible Dependents, who are eligible for **Medicare**, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to **Medicare** (age, ESRD, or disability) and the effective date of **Medicare** Part A and Part B.

If the Covered Person becomes entitled, including dually entitled, to **Medicare** based on ESRD, the Plan will reimburse the Covered Person up to a lifetime maximum amount of $5,000 for **Medicare** Part B monthly premiums made during the period where the Plan has primary status. Reimbursement for monies withheld by **Medicare** from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter. The **Plan Administrator** may require documentation of the payment of Part B premiums. For additional information on how to submit a new request for reimbursement of Part B premiums, please contact the **Plan Administrator**.

For more information on benefits available under the **Medicare** program, visit www.medicare.gov or call toll-free 1 (800)-MEDICARE (1 (800) 633-4227). For more information on Medicare Part B premiums, visit www.socialsecurity.gov, the local Social Security office or call Social Security at 1 (800) 772-1213.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits":

- Dialysis treatment performed in:
  - the **outpatient** department of a **hospital**,
  - a facility recognized by **Medicare** for dialysis, or
  - the patient's home.

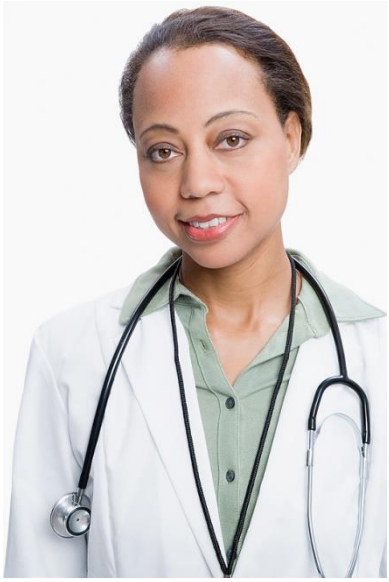
What If I Need To See A Physician?

There are many types of **physician** related services that are covered under the plan. Services may be for **inpatient** and/or **outpatient** treatment, including consultations and office visits.

Preparing For A Physician Visit

In most cases, your **physician** will see you for less than 10 minutes. To prepare and make the most of a **physician** visit, whether on an **inpatient** or **outpatient** basis, you may want to do the following:

- Write down your most important concerns
  - Symptoms, including when they first occurred and how often they occur,
  - History of the problem, including whether you have had the problem before and how long ago,
  - Treatments you may have tried.
    - Bring records of information (medical records from other current or previous **physicians**, medications you currently take or have previously taken, including dosage information and over-the-counter medications, other health problems, etc.)
- Bring along a family member to help you with questions and/or any instructions your **physician** might give you.
- Take notes and ask questions or ask for further explanations regarding your health.
- Follow your **physician's** recommended treatment.



What Is A Consultation?

A consultation is a meeting of two or more health professionals to discuss the **diagnosis**, prognosis, and treatment of a particular case.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- Consultations, including those:
  - for medical conditions that require **surgery**;
  - for medical conditions that do not require **surgery**; and
  - provided by a **physician** (other than the attending **physician**) during a **hospital confinement**.
- Office exams provided to treat an **illness** or **injury**.
- Charges relating to chiropractic care, up to one treatment per day. Coverage may include spinal and osteopathic manipulations (which include the full spine), spinal x-rays, **physical therapy** and office visits.
- Charges associated with injections to treat an **illness** or **injury**, including antigens and serums.
- Charges associated with contraceptive injections.
- Charges related to **outpatient mental disorders** and substance abuse treatment when rendered by a **physician** or **health care professional**, who is licensed, accredited or certified, to perform specific health services consistent with state law.

What If I Need Surgery?

There are many reasons why someone may need to have **surgery**. Some **surgeries** are due to an **emergency**, but most **surgeries** today are elective. By having an elective **surgery**, you have time to learn more about your **surgery** and find out if it is the best treatment for you.

A surgical procedure may consist of a cutting operation, suturing of a wound, treatment of a fracture, relocation of a dislocation, radiotherapy (if used in lieu of a cutting operation), diagnostic and therapeutic endoscopic procedures, or laser **surgery**. Also certain injections are also classified as **surgery**. The plan will cover charges related to a surgical procedure as described below, including charges for blood that has not been replaced by donation and charges for you to store your blood for **surgery** at a later time.

Preparing For Surgery

Prior to your elective **surgery**, there are many questions you can ask your **physician**:

1. Why do I need to have **surgery** and what will happen if I do not have **surgery**?
2. Are there any alternatives?
3. Are there any risks or side effects associated with the surgical procedure?
4. How long will it take for me to recover?
5. Should I get a second surgical opinion?
6. What do I need to do to prepare for **surgery**?

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- **Inpatient** or **outpatient surgery** performed in a **hospital**, ambulatory surgical center, urgent care facility or **physician's** office, including:
  - facility charges;
  - surgeon's charges;
  - surgical assistance provided by a physician's assistant or another **physician** for surgical procedures that need an assistant; and
  - related anesthesia when administered by a **physician** (other than the operating or assisting **physician**) or a Certified Registered Nurse Anesthetist (CRNA).
- Diagnostic surgical procedures.
- Routine Colonoscopy – age 50+; one every 5 years.
- Placement or replacement of functional implants (e.g., pacemaker, defibrillator, insulin pump, artificial limb) or non-functional implants (e.g., breast implant).
- The removal of sutures provided the plan covers the initial placement of the suture, and the suture is removed by a **physician** other than the **physician** who initially placed it.

- Breast reduction, when **medically necessary** and there is removal of 250 grams of tissue per breast.
- Removal of warts through repetitive procedures for dissolving warts either by heat or freezing methods.
- Acupuncture, when administered by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO), and used as an anesthetic in connection with a covered **surgery** or to relieve chronic pain.
- Sterilization, including tubal ligations or vasectomies (applies to an **employee** or his or her **covered spouse**, or covered female **dependent**).
- **Physician** and facility charges for an **inpatient** or **outpatient** abortion procedure, (for you, your **spouse** and **dependent** children) when **medically necessary** due to rape, incest, or when the mother's life is endangered if carried to term.
- Oral surgical procedures and other related services, when performed by a **physician** (MD or DO), Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD), limited to:
  - incision and drainage of abscess,
  - excision of cyst,
  - resection of benign tumor or soft tissue,
  - sialolithotomy,
  - closure of salivary fistula,
  - extraction of impacted teeth,
  - **dental surgery** not specifically listed if it would be covered if the same type of procedure were performed on another part of the body, and
  - repair to the jaw, mouth or face or repair/replacement of a **dental** appliance or **sound natural teeth** due to an accidental bodily **injury**. Treatment must be completed within one year of the **injury**, unless the healing process delays treatment.
  - **surgery** and/or x-rays related to the treatment of TMJ.

NOTE: **Dental** procedures covered under a **dental** plan maintained by the **employer** are <u>not</u> covered under this medical plan. Any remaining charges will be your responsibility.

- Surgical procedures related to vision services, including:
  - surgical removal of cataracts,
  - first pair of eyeglass lenses and frames or contacts after cataract **surgery**,
  - retinal reattachment,
  - implantation of a **prosthetic device**,
  - surgical correction of strabismus (crossed eyes),
  - cornea repair,
  - medical treatment for eye infections (conjunctivitis) and glaucoma,
  - treatment for **injury** to the eye,
  - removal of a foreign body from the eye, and
  - other treatment of a medical condition that happens to affect the eye that would be covered by this plan if manifested in any other part of the body (example – excision of cyst)
- Surgical procedures related to covered hearing including:
  - **physician's** charges related to **surgery**; and
  - related anesthesia and facility charges.

Second Surgical Opinions

The plan does not require that you obtain a second surgical opinion for an **inpatient** or **outpatient surgery**. However, getting a second surgical opinion from another **physician** is a good way to ensure that your **surgery** is **medically necessary** and the appropriate **surgery** for you. Your **physician** may refer you to another **physician** for a second opinion or you can coordinate a second opinion from any **physician** of your choice.

The plan pays for the cost of the second opinion exam provided the **physician** performing the second surgical opinion submits the charge as a second surgical opinion consultation. If you have a second opinion, you must request that the **physician** providing the second surgical opinion submit the charge as a second surgical opinion consultation.

Women's Health And Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your **plan administrator**.

What If I Need Anesthesia?

The plan pays for anesthesia associated with a covered surgical procedure. Your **physician** will inform you whether or not your surgical procedure requires anesthesia. There are three types of anesthesia that your **physician** may choose:

- Local anesthesia is injected in tissue and numbs a small portion of your body and only for a short period of time. This type of anesthesia is generally reserved for **outpatient** procedures and skin and soft tissue **surgery**, in which a small incision and no deep penetration occur. Charges for this type of anesthesia are included in the surgeon's bill and no additional billing would be payable.
- Regional anesthesia is injected into a cluster of nerves and numbs a larger portion of your body (e.g., arm, leg or the lower portion of your body) for a few hours. During the time you are under this type of anesthesia, you may be awake and given a sedative.
- General anesthesia is administered intravenously or by inhalation. With this type of **surgery** you are not conscious during **surgery**.

When you decide to have **surgery**, ask to meet with the anesthesiologist (**physician** or a Certified Registered Nurse Anesthetist (CRNA)) who will be administering the anesthesia. When meeting with the anesthesiologist, you may want to ask the following questions:

1. How long will I be under anesthesia?
2. What are the side effects of having anesthesia?
3. I am taking prescribed medications, vitamins and/or supplements, does this pose any risk?
4. Are there specific risks for someone my weight, height and age?
5. Is any special consideration taken if I am a smoker?

Weight Management

Any expenses, whether surgical, non-surgical, or therapeutic (including **prescription drugs**) that are related to weight management or the treatment of obesity will not be covered under the plan regardless of the existence of any co-morbid conditions or psychological condition, unless the patient is morbidly obese as described below.

For purposes of determining morbid obesity, the plan will base the determination of morbid obesity on the patient's Body Mass Index (BMI) or overweight status. A BMI equal to or greater than 40, or more than 80 pounds overweight for a female or more than 100 pounds overweight for a male will be considered indicative of morbid obesity. A BMI equal to or greater than 35 but less than 40 will also be considered indicative of morbid obesity where the patient has one or more of the following co-morbid conditions; severe sleep apnea, Pickwickian syndrome, congestive heart failure, cardiomyopathy, Insulin dependent diabetes or severe musculoskeletal dysfunction, that are either life-threatening or which significantly impair a major life function (e.g., mobility, ability to work, ability to self care). Additionally, the plan will review patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. For example, this review will consider whether the patient has been unable to lose weight through non-surgical, conventional measures and whether the individual's ability to manage the surgical intervention and required post operative care has been assessed through a psychological evaluation. Unsuccessful weight loss attempts and lifestyle changes should be documented by medical office progress notes.

All expenses related to the treatment of morbid obesity that are otherwise payable under the plan will be considered allowable expenses (e.g., **surgery**, hospitalization, anesthesia, office visits for a **physician**, lab testing, psychotherapy, etc. Services will be payable as described in each respective section).

Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of morbid obesity will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.
2. Subsequent panniculectomy [**surgery** to remove loose skin] resulting from weight loss will be covered only if it is **medically necessary** as a result a documented history of treatment by a **physician** for skin related **illnesses** for a minimum of six months where the treated condition is no longer controlled through any other means.

What If I Need Therapy?

A very important part of the treatment and recovery process may be some type of therapy. Therapy can help strengthen parts of the body that have lost function. In some cases therapy may be the only needed treatment for your condition. In other cases therapy may be part of a treatment program designed to assist with your recovery. You and your **physician** will decide what type of therapy is right for you.

Below are several questions you may want to ask your **physician** or therapist as you begin therapy:

1. What type of therapy am I receiving?
2. Why is this the right type of therapy for my condition?
3. How often will I need therapy?
4. How long will my treatment continue?
5. Where will the treatment be performed?
6. At what point will my progress be evaluated?
7. What type of activities will my therapy consist of?

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- Occupational therapy prescribed by a **physician** and necessary to improve, develop, or restore physical functions lost or impaired due to **illness** or **injury**. Services must be rendered by a **physician** or a **health care professional**.
- **Physical therapy** prescribed by a **physician** and necessary to improve, develop, or restore physical function lost due to **illness**, **injury**, or a covered surgical procedure. Services must be rendered during a covered **hospital confinement**, in the **outpatient** department of a **hospital**, a free-standing **physical therapy** center, a **Medicare** approved rehabilitation facility or a **physician's** office. Services must be rendered by a **physician** or a **health care professional**.
- Speech therapy when prescribed by a **physician** and necessary to restore or improve a speech disorder that results from **illness** or **injury**, or to treat speech delay where the delay is caused by an identified **illness**, **injury** or when following **surgery** for a **congenital defect**. Services must be rendered by a **physician** or a **health care professional**.
- Phase 1 and Phase 2 cardiac rehabilitation for those patients with certain cardiac conditions who would materially benefit from cardiovascular exercise, and who are unable to engage in unsupervised exercise without a clear risk of an acute cardiac event. Cardiac rehabilitation should be initiated as soon after the cardiac event as it is safe to begin (depending on the condition, typically no more than 6-12 months after a **surgery** or procedure is performed). Services must be provided by a **Medicare** approved facility in accordance with **Medicare** guidelines.

What If I Need A Transplant?

When you or your family member prepares to undergo transplantation, it can cause great emotional and physical strain. By doing some research and learning what to expect, you will be better prepared and ensured a successful procedure; being prepared means taking these extra steps prior to the time of **surgery**:

1. Stay Positive – Good emotional health will help increase your body's health. Be sure to talk to your **physician** about stress and anxiety management, and find out what types of services may best help you manage your health.
2. Get Educated – Ask lots of questions! Your **physician** and transplant team will be able to provide you with information to help you understand the procedure and its risks, as well as what to expect once the procedure is completed.
3. Get Support – Family and friends are a crucial lifeline for many transplant patients. However, there are also support groups that are intended to help you manage the numerous emotions that are common to transplant patients. Again, your **physician** and transplant team will be able to assist you with locating support groups in your area.
4. Get Financially Ready – Talk to your **physician** and the team at the transplant center regarding the procedures that will be performed as well as the expected reimbursement through your medical plan. Also, be sure to ask about the transplant network and how you can maximize your benefits by utilizing its resources.

Your Transplant Network

Certain medical expenses, including skin tissue and bone marrow, associated with a necessary non-experimental human organ transplant are covered as provided below.

Gunnison County, Colorado has contracted with OptumHealth to be your transplant network. OptumHealth is an independent contractor and provides centers of excellence for specific types of transplant procedures. Services rendered by an OptumHealth provider are payable at the Network level.

The centers of excellence found in the OptumHealth network have been specifically screened based on the high quality of services provided and the higher than normal successful outcome rates these facilities have experienced. By utilizing facilities with a history of successful outcomes, the likelihood of a successful outcome increases for you or your covered **dependent**.

The network benefit level shown in the Overview of Benefits is only available when you fully participate in the Special Transplant Program and meet all of the requirements and guidelines stated below:

1. Pre-notification must be made by the **covered individual**, their **physician** or **Plan Administrator** as soon as the **covered individual** is identified as a potential transplant candidate; and
2. Pre-certification must be obtained from NGS CoreSource.

Whenever you or your covered family member chooses an OptumHealth provider, you may experience a savings. The savings is created because network services are provided at a discount, resulting in a lower copayment for you.

While this plan has arranged these discounts when an OptumHealth provider is utilized, it is important to remember that you may be treated wherever you and your **physician** deem appropriate. You, together with your transplant team, are ultimately responsible for determining the appropriate treatment regardless of coverage by this plan.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits:"

- **Physician and facility** charges related to the **surgery**, including charges for a surgical **physician's** assistant and related anesthesia.
- Harvesting, storage and transportation costs related to the donated organ.
- Charges for transportation of patient and a companion.
- Donor's medical expenses when the recipient is a **covered individual** and the donor has no source of coverage, up to the plan maximum.

What Is Not Covered?

These exclusions will apply only to transplant expenses. Please see the "What is Not Covered?" section for all other plan exclusions.

- Expenses of a **covered individual** who donates an organ unless no other source of coverage.
- Fees charge**d** by blood and organ donors.
- Expenses incurred while waiting for a human organ transplant (Examples - housing, transportation, living expenses), unless the Transplant Network is utilized.
- Services related to obtaining or implanting a non-human, artificial or mechanical organ.
- Transplant procedures that are considered **experimental**.
- Transplant procedures that are considered **experimental**.

What If I Need A Prescription Medication?

Understanding the importance your medication plays in your treatment will help you get the greatest benefit from your prescription. It is important to take an active role in your health care by working with your **physician**, **nurse**, and pharmacist to learn as much as possible about your prescription.

Four Ways To Make Your Medications Work For You

1. Give Your Health Care Team Important Information

- Be a partner with your health care team. Tell them about:
  - All the medicines, vitamins, herbals, and dietary supplements you are already taking, including prescription medications, vitamins, dietary supplements and over the counter medications.
  - Any allergies or if you have had problems when taking a medicine before.
  - Any other **illness** or medical condition you have, like diabetes or high blood pressure or if you are pregnant, considering becoming pregnant or nursing a baby.
  - Any concerns you might have with the cost of the medication. There may be another medicine that costs less and will work similarly.

2. Get The Facts About Your Medicine

- **Be Informed**
  - Ask questions about every new prescription medicine.
- **Read The Prescription**
  - If your **physician** writes your prescription by hand, make sure you can read it. If your **physician** submits your prescription to the pharmacy electronically, ask for a copy of the prescription.
- **Know What Your Medicine Is For**
  - Ask your **physician** to write down on the prescription what the medicine is used for...not just "take once a day" but "take once a day for high blood pressure."
- **Ask Questions**
  - If you have other questions or concerns:
    - Talk to your **physician** or pharmacist.
    - Write questions down ahead of time and bring them to your appointment.

3. Stay With Your Treatment Plan

Now that you have the right medicine, you will want to carry out the treatment plan. But that is not always easy. The medicines may cause side effects. Or you may feel better and want to stop before finishing your medicines.

- **Take all the antibiotics you were prescribed.** If you are taking an antibiotic to fight an infection, it is very important to take all of your medicine for as many days as your **physician** prescribed, even if you feel better.
- **Ask your physician if your prescription needs to be refilled**. If you are taking medicine for high blood pressure or to lower your cholesterol, you may be using your medicine for a long time. If you run out of refills, it may be time to see your **physician**.
- **Tell your physician about any side effects**. You may be able to take a different amount or type of medicine.
- **Never give your prescription medicine to somebody else** or take prescription medicine that was not prescribed for you, even if you have the same medical condition.
- **Ask whether you need** blood tests, x-rays, or other lab tests to find out if the medicine is working.

4. Keep A Record Of Your Medicines

- **Keep track of what medications you are taking**. Make sure that your list includes information about the name of the medication, the dosage and how long you have been taking the medication.
- **Include non-prescription medications**. Many people take a vitamin or a dietary supplement or some other type of non-prescription medication. Sometimes these can interact with your prescription medications. Make sure your list of medications includes both the prescription and non-prescription medications you are taking.
- **Keep the list up to date**. If you begin taking a new medication – or stop taking a medication – be sure to revise your list. Also, make revisions if your dosage changes.
- **Put the list in a safe place**. Make sure you will be able to find it in an **emergency**. Tell your family members and friends where they can find your list.
- **Take the list with you to your physician appointments, hospital and visits to the emergency room or urgent care center**. The **physicians** and **nurses** at these facilities will need to know what medications you have been taking. This will assist them in providing the best possible treatment.

Purchasing Decisions About Prescription Medications

- **In a medical facility**
  - In some cases you or your **dependent** may receive prescription medications in your **physician's** office, from a **hospital** on an **inpatient** or **outpatient** basis, from a surgical center, through a **home health care agency** or through **hospice** or for dialysis or chemotherapy. In these situations your medications will be covered as described in the respective section of this **SPD**. The charges from these facilities will be subject to, when applicable, the plan's **deductible**, any applicable plan maximums and any applicable exclusions. You may wish to ask your **physician** if the medication can be obtained through the pharmacy as it is likely that those medications received from the pharmacy will receive a greater discount.

- **In the pharmacy**
  - **Prescription drugs** purchased at a participating pharmacy are covered by the **prescription drug** benefit administered by CVS Caremark. Each new or refilled **prescription drug** will be payable as described in the section titled "Overview of Benefits." There is a **prescription drug deductible** of $100 per person in a calendar year. This **prescription drug deductible** is separate from this plan's **deductible** and **out-of-pocket maximum**. Your **prescription drug** co-pays will not be applied to this plan's **deductible** and **out-of-pocket maximum** expense limit.

    The participating pharmacy will fill the prescription with a generic substitute, unless the **physician** writes, "dispense as written" on the prescription or a generic substitute is not available. If you or your **physician** request a brand name drug when a generic drug is available, you will be required to pay the cost difference between the brand name drug and the generic drug in addition to the brand name co-pay.

- **In a non-network pharmacy**
  - If you or your **dependent** purchases a drug at a non-participating pharmacy, there is no benefit.

- **By mail order**
  - Maintenance drugs (those prescribed to treat long-term or chronic medical conditions) can be obtained by mail through CVS Caremark. **Prescription drug** mail order forms are available through your Human Resources Department. When you use a **prescription drug** mail order provider, you can receive a 90-day supply for one co-pay.

    The participating pharmacy will fill the prescription with a generic substitute, unless the **physician** writes, "dispense as written" on the prescription or a generic substitute is not available. If you request a brand name drug when a generic drug is available, you will be required to pay the cost difference between the brand name drug and the generic drug in addition to the brand name co-pay.

What Is Covered?

- Federal legend drugs (Federal legend drugs are medications that require a **physician's** prescription to be dispensed).
- Compounded medication - mixed to order medications which contain at least one Federal legend drug.
- Diabetic supplies.
- Insulin and syringes when dispensed with insulin.
- Oral contraceptives.
- Contraceptive injectables and patches.
- Legend pre-natal vitamins.
- Retin-A for **covered individual** under age 35.
- Acne treatments (Accutane subject to prior authorization with Letter of Medical Necessity).
- HIV/AIDS related medications.
- Immunosupressants.
- Injectable bee sting/Ana kits.
- Blood glucose meters.
- Migraine Medications (Imitrex), limited to the following:

Nasal Sprays	Six sprays (one bottle)	every 22 days
Injections	Four injections (two kits)	every 22 days
Oral Pills	Nine pills (six for Maxalt)	every 22 days

- Preventive Drugs as required by the **Patient Protection and Affordable Care Act (PPACA)**.

What Is Not Covered?

BELOW ARE MEDICATIONS THAT ARE NOT COVERED WHEN OBTAINED THROUGH A PHARMACY (PARTICIPATING OR NON-NETWORK) OR MAIL ORDER.

- Non-legend drugs.
- Contraceptive devices (Please refer to the section titled "Supplemental Services and Supplies" for further information).
- Fertility drugs.
- Sexual dysfunction agents (Viagra).
- Cosmetic indicators (including Rogaine).
- Injectables (other than insulin/bee sting).
- Growth hormones.
- Smoking cessation agents.
- Legend vitamins (other than pre-natal).
- Anorexiants (unless for weight control of PA documented cases 100+ lbs overweight).

What If I Need A Specialty Injectable Medication?

The CVS Caremark Specialty Pharmacy is available for certain medications related to the conditions or treatment programs listed below. The **company** has elected to work with CVS Caremark Specialty Pharmacy to enhance and assist in the management of these specialty medications. Services include enhanced customer service and substantial discounts through volume discount manufacturer pricing. These discounts may reduce your cost.

To receive these specialty drugs, simply provide a copy of your identification card to your **physician**. Your **physician** will submit the prescription.

The CVS Caremark Specialty Pharmacy must be used for certain medications related to the conditions or treatment programs listed below. You can fill your prescriptions up to two times at retail. However, after your first two prescription fills, you must transition to the CVS Caremark Specialty Pharmacy.

- Asthma
- Chronic Renal
- Crohn's Disease
- Endocrinology
- Fabry's Disease
- Fertility
- Gaucher's Disease
- Growth Hormone
- Hematology/Cardiology
- Hemophilia
- Hepatitis
- Immune Therapy
- IVIG
- Multiple Sclerosis
- Neurology
- Oncology
- Oncology Adjunct
- Ophthalmology
- Osteoarthritis/Rheumatoid Arthritis
- Pain Management
- Parkinson's
- Psoriasis
- Pulmonary
- Pulmonary Fibrosis
- Pulmonary Hypertension
- Rabies
- Other Disorders

SUPPLEMENTARY SERVICES AND SUPPLIES

The best course of treatment for you may not include hospitalization, diagnostic testing, or other services previously described. Rather, your condition may require specialized care or supplies in conjunction with the services being provided by your **physician**. These benefits supplement other coverage described throughout this document to complete the comprehensive program offered by your employer.

Medical Equipment, Medical Supplies, Orthotics And Prosthetics

This plan pays benefits for medical equipment and supplies that you and your family members may need to assist you with an **illness**, **injury**, or **congenital defect**.

What Is Covered?

Charges will be covered as described below and will be payable as described in the section titled "Overview of Benefits":

- Rental or purchase of medical equipment, such as wheelchairs, glucose watches, traction equipment, walkers, **hospital** beds and mattresses and hemodialysis machines. In certain cases of uncontrolled diabetes glucometers, dextrometers and portable insulin infusion pumps may be considered durable medical equipment

  NOTE: This plan may elect to purchase the durable medical equipment if it would be less costly than continued rental. If this occurs, the durable medical equipment is the property of this plan and must be surrendered when the patient for whom it was purchased no longer requires the equipment or becomes ineligible for coverage under this plan. You (or a responsible person) will be required to sign a purchase agreement if the plan elects to purchase medical equipment.

- Medical supplies and dressing that are needed to help you manage your condition, including, but not limited to: such jobst hose, colostomy supplies, dressing packs, incontinence pads, crutches, canes, splints, trusses, oxygen and therapeutic gases, syringes and needles, etc.
- Charges for IUDs.
- Blood test sticks used by diabetics and prescribed at the same time as insulin needles.
- Orthotic appliances such as braces, shoes, when an integral part of a corrective brace, and custom molded items.
- Temporary and long-term prostheses.
- Prosthetic devices, as well as their replacement as needed due to the patient's growth or physiological change, or every 3 years due to wear and tear.
- Necessary repairs to covered medical equipment, orthotic appliances and prosthetic devices.

Infertility

Conceiving a child is difficult for some individuals, but often there is treatment available to aid you with reaching your goal of having a family.

What Is Covered?

This plan provides the benefits described below. These benefits are payable as described in the section titled "Overview of Benefits:"

- Testing to determine the cause of **infertility**.
- Corrective surgical procedures.

Complementary/Alternative Medicine

There are times when conventional medicine may not meet a **covered individual's** physical or emotional needs. However, there are certain alternative therapies which may offer assistance, and those services are considered "complementary and alternative medicine." This plan provides the benefits for the alternatives described below.

What Is Covered?

These benefits are payable as described in the section titled "Overview of Benefits:"

- Naturopathy care.
- Acupuncture/acupressure.
- Nutrition therapy.
- Rolfing.
- Therapeutic massage.

WHAT IS NOT COVERED?

While the plan provides a thorough and comprehensive level of coverage for you and your covered **dependents**, not every service is covered. The following is a list of services which are not covered by any portion of the plan.

1. **Abortion**. **Physician** and facility charges for an **inpatient** or **outpatient** abortion procedure, unless due to rape, incest, endangerment of the mother's life if pregnancy is carried to term, or if therapeutic as determined by genetic counseling.
2. **Acupuncture and Acupressure**. Acupuncture and/or acupressure, unless otherwise specified.
3. **Adoption Expenses**.
4. **Ambulance**. The plan does **not** pay benefits for anything other than professional ambulance transportation charges, such as:
   - transportation from a **hospital** to the patient's home, unless home health care program is in place,
   - travel charges for regularly scheduled plane or train transportation,
   - transportation for the convenience of the patient, and
   - transportation by other than a professional ambulance service, except as otherwise provided.
5. **Amniocentesis**. Amniocentesis to determine the gender of the newborn or in the absence of known risk factors including but not limited to, maternal age, previous child with chromosomal disorder, abnormal ultrasound, or family history or other documented risk of a detectable, single gene disorder.
6. **Anesthesia Separate Charges**. Charges billed separately by an anesthesiologist and a CRNA that, when the bills are combined, exceed **reasonable and customary**.
7. **Appliances**. This plan does not pay benefit for **dental** guards, dentures, orthodontic braces, and similar appliances.
8. **Auto Accident**. Expenses as a result of an auto accident in an uninsured motor vehicle where no-fault insurance is compulsory
9. **Behavioral Modification Programs**. Charges related to behavioral modification programs.
10. **Biofeedback**. Charges related to biofeedback training.
11. **Chiropractic Care**. Chiropractic care when provided by a Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) - other than office visits, spinal x-rays, spinal or osteopathic manipulations, prescribed orthotic appliances, injections or **physical therapy** if the Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) is within the scope of their license in the state in which they practice and are legally permitted to perform services for which coverage is provided in this plan.
12. **Claim Forms**. Charges incurred for completion of claim forms.
13. **Claims Filing Deadline**. Claims filed later than one year from the date the charge was incurred.
14. **Confinements for Not Covered Procedures**. Any **hospital** or other facility charges for procedures or confinements that the plan does not cover.

15. **Confinements for Testing/Physical Therapy**. Confinements solely for diagnostic testing, x-rays, physical checkups, **physical therapy**, observation, and rest cures except when due to a **concurrent hazardous medical condition**.

16. **Convenience Items**. Convenience items such as telephones, televisions, guest meals, guest beds, haircuts, manicures, etc.

17. **Coordination of Benefits**. Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits.

18. **Cosmetic Procedures**. Cosmetic procedures unless necessary:
    - due to an **illness** or **injury** and performed within one year of the **illness** or **injury**, unless a medical reason delays treatment.
    - as a result of a **congenital defect** which interferes with bodily functions and performed within one year of the **illness** or **injury**, unless a medical reason delays treatment.
    - for scar revision to correct a deformity caused by an accidental bodily **injury** or **surgery** and performed within one year of the **illness** or **injury**, unless a medical reason delays treatment.

19. **Custodial Care**. Charges/confinements for **custodial care** (services which primarily help an individual perform daily living activities).

20. **Days of Confinement**. This plan does not pay benefits for days of **hospital confinement** prior to the day of your elective **surgery**.

21. **Days on Leave**. Charges for days when you or your covered **dependents** are not confined in the **hospital** (days when the patient is on leave from the **hospital**).

22. **Dental**. **Dental** expenses for the following:
    - **Hospital confinements** or **hospital outpatient** expenses during which only **dental** services or oral surgical procedures are performed, unless necessary due to a **concurrent hazardous medical condition**, a medical need to utilize the facility or due to the age of the patient (age 5 and under).
    - Charges related to **dental** services, procedures or prosthesis, except as specifically provided.
    - **Dental** x-rays, except when performed in connection with a covered oral surgical procedure.

23. **Dental Procedures**. **Dental** procedures other than those listed in the section titled "What If I Need **Surgery**?"

24. **Dental X-Rays**. **Dental** x-rays and their interpretation, unless related to and **medically necessary** for **dental** procedures specified under the section titled "What If I Need Surgery?"

25. **Dietary Supplements**. Charges for oral dietary supplements that contain a dietary ingredient intended to supplement the diet.

26. **Duplicate Tests**. Duplicate tests by different **physicians**, except when **medically necessary** to monitor a patient's medical condition.

27. **Educational Training/Testing**. Educational testing and training.

28. **Eligible for Benefits**. Charges for services which began before the **covered individual** was eligible for benefits.

29. **Environmental Control Equipment**. This plan does not pay benefits for equipment such as air conditioners, air filters, humidifiers, vaporizers, etc.

30. **Errors in Refraction**. Testing to determine errors in refraction, unless due to an **injury** or following a covered **surgery**.

31. **Eyeglasses and Contact Lenses**. Charges for eyeglasses and contact lenses, unless provided to Aphakic patients.

32. **Experimental/Investigational**. **Experimental** or **investigational** care, treatment, services, supplies or drugs.

33. **Failure to Comply with another Plan**. Charges that are not payable by the primary plan covering the patient solely due to the patient's failure to comply with that plan's requirements for cost containment provisions (including – but not limited to - failure to pre-certify).

34. **Failure to Comply with this Plan**. Charges that may otherwise be payable when you or your provider fail to comply with this plan's request for information.

35. **Family Providers**. Services, care and treatment rendered by you or your **spouse**'s mother, father, grandmother, grandfather, in-laws, brother, sister, half-brother or half-sister, son, daughter, stepchildren, aunt, uncle, cousin, niece, nephew, grandson, granddaughter, or anyone who resides with you or your **spouse**.

36. **Felony**. Charges incurred as a result of committing, or attempting to commit, an assault or felony or from a covered participant's engaging in an illegal occupation.

37. **Fertility Treatment**. Counseling, treatment, (artificial insemination, in-vitro fertilization, hormonal therapy, in-vivo fertilization or GIFT, embryo transfer, fertility drugs) other than services to diagnose the cause of **infertility**, surgical procedures to correct **infertility** as listed in the section titled "**Infertility**".

38. **Fetal Surgery**. Fetal **surgery** and related charges when the procedure is **experimental** or not performed to enhance or protect the outcome of the pregnancy.

39. **Foot Care**. Charges for foot care, including treatment (other than **surgery**) of corns, bunions, toenails, calluses, flat feet, fallen arches, weak feet and chronic foot strain when performed in the absence of a localized **illness**, **injury** or symptoms involving the foot.

40. **Government/Military Hospital**. Services provided in a **hospital** operated by the U.S. government (or an agency of the government, such as a V.A. or military **hospital**) for an armed-services-related medical condition.

41. **Governmental/State**. Charges for which coverage is required by or available through any federal, state, municipal or other governmental body or agency, unless care is rendered in a Veteran's Administration Hospital for a non-service connected **injury** or **illness**.

42. **Hair Analysis**. Charges for hair analysis.

43. **Health Club Membership**. Membership costs included, but not limited to health clubs and weight loss programs.

44. **Hearing**. Charges for cochlear implants.

45. **Home Testing**. Charges for home testing kits.

46. **Homemaker Services**. Charges for homemaker or housekeeping services.

47. **Homeopathic Care**. Herbal medicines, holistic or homeopathic care, including drugs, except as otherwise provided. Refer to the section titled “Complimentary/Alternative Medicine”.

48. **Hospice**. Charges for funeral arrangements, pastoral counseling and financial/legal counseling.

49. **Hypnotherapy**. This plan does not pay benefits for hypnotherapy.

50. **Illegal Activity**. Charges incurred as a result of committing, or attempting to commit any illegal or criminal activity, unless the **illness** or **injury** is a result of a physical or mental condition.

51. **In-Vitro**. Artificial insemination, in-vitro fertilization and embryo transfer.

52. **Incomplete Claims Submission**. Charges when there has been an incomplete claim submission.

53. **Late Discharge**. Charges for “late discharge” or “late check-out” if the discharge results from convenience.

54. **Learning Disabilities**. This plan does not provide benefits for the treatment of **learning disabilities**.

55. **Legal Expenses**. Charges for legal expenses or fees incurred in obtaining medical treatment or payment of claims.

56. **Massage Therapy**. Charges for massage therapy, except as otherwise provided. Refer to the section titled “Complimentary/Alternative Medicine”.

57. **Medically Necessary**. Services and supplies that are not **medically necessary**.

58. **Medical Equipment**. Rental charges that exceed the purchase price of the equipment.

59. **Medical Supplies**. Charges for a specially designed bra for a breast prosthesis, exercise equipment, blood pressure kits, diet scales, etc.

60. **Military Services**. Treatment or services resulting from or prolonged as a result of performing a duty as a member of the military service of any state or country.

61. **Not Required to Pay**. Charges that you would not be required to pay if you did not have group health coverage.

62. **Nuclear Contamination**. Expenses incurred as a result of radioactive contamination, or the hazardous properties of nuclear materials.

63. **Observation Care**. Charges for 23-hour **outpatient** observation care in excess of the cost of one day care at the **hospital's** semiprivate room rate.

64. **Office Visits and Other Expenses for Marriage, Employment, Licensing or Regulatory Purpose**. Office visit charges for pre-employment, premarital, or any examinations required by licensing, regulatory, or other such purpose (unless otherwise specified).

65. **Paternity**. Charges for paternity testing.

66. **Phone/Internet Conversations**. Charges for medical treatments, consultations or visits that consist of a telephone or internet conversation or other electronic communication.

67. **Plan Maximums**. Charges in excess of plan maximums.

68. **Private Duty Nursing**.

69. **Providers Not Covered**. Services rendered by a provider who is not specifically included in the definition of a **physician** or specifically listed as a covered provider.

70. **Reasonable and Customary**. Charges in excess of those considered **reasonable and customary**.

71. **Recreational, Music, and Remedial Reading Therapy**.

72. **Research Studies**. Services and supplies provided through research studies.

73. **Riots/Nuclear**. Treatment or services relating to a riot, civil disobedience, nuclear explosion or nuclear accident.

74. **Self-Inflicted**. Charges incurred as a result of an intentionally self-inflicted **illness** or **injury**, unless the **illness** or **injury** is a result of a physical or mental condition.

75. **Services Not Rendered**. Charges for services or supplies not rendered (including charges for canceled appointments).

76. **Sexual Conversion**. Surgical and other related medical charges associated with sexual conversion, gender reassignment, or disturbance of gender identification.

77. **Shock Therapy**.

78. **Skilled Nursing Facility**. Confinements for **mental disorders**, substance abuse and **custodial care**.

79. **Smoking Cessation**. Charges for services related to smoking cessation, except as otherwise provided under **required preventive care**.

80. **Standby Physician**. Charges for a standby **physician**, except when required because of a **hospital** policy or state law or ordered by the delivering **physician** or surgeon.

81. **Sterilization Reversal**. Sterilization reversal and all related charges.

82. **Surrogacy**. Charges incurred by a **surrogate mother**.

83. **Thermography**. Charges for thermography, thermogram, or thermoscribe.

84. **Travel**. Any type of travel whether or not recommended by a **physician**, except in connection with covered ambulance and transplants.

85. **Vision**. Charges for radial keratotomy, LASIK, refractive keratoplasty or similar procedures.

86. **Vitamin Injections**. Charges for vitamin injections, unless the injections are for a diagnosed medical condition or when substitution with over-the-counter medication would endanger the patient's well being.

87. **War**. Charges for services resulting from or prolonged as a result of participating in a war or act of war, whether declared or undeclared.

88. **Wigs**. Charges for wigs or hair prosthesis.

89. **Worker's Compensation**. Services rendered for treatment of any **injury** or **illness** for which benefits are available under or entitled to under a Worker's Compensation, Employer Liability Law (if required by law) or occupational disease contract, whether or not such contract is actually in force.

Physical Examination

This plan, at its own expense, will have the right and opportunity to have any individual whose medical or **dental** treatment is the basis of a claim under this plan, examined by a **physician** designated by this plan when and as often as it may be reasonably required during the review of a claim under this plan.

COORDINATION OF BENEFITS (COB)

Today many people have more than one source of benefit coverage. Because of this, the plan has a coordination of benefits (COB) feature that helps to avoid duplication of payments for the same services. Not only does it prevent duplication of payments, it also makes sure that you are receiving the maximum benefit for which you are entitled.

This plan will coordinate benefits with any plan, policy, or coverage providing benefits or services for, or by reason of medical, dental, or vision care. (This plan shall mean any portion of the **company's** plan which provides benefits that are subject to the applicable COB provisions that may be reduced because of the benefits of other plans.) These other plan(s) may include, without limitation:

- Group insurance or any other arrangement for coverage for **covered individuals** in a group, whether on an insured or uninsured basis, including, but not limited to **hospital** reimbursement-type plans;
- **Hospital** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
- A licensed Health Maintenance Organization (HMO);
- Any coverage under a government program and any coverage required or provided by any statute;
- Group/individual automobile insurance coverage, including coverage based upon the principles of "No-fault" coverage;
- Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
- Labor/management trusteed, union welfare, employer organization, or **employee** benefit organization plans.

This **plan** will not coordinate benefits with hospital indemnity or other fixed indemnity plans; accident only, specified disease, limited benefit health coverage; school accident type coverage; medical supplemental plans; and Medicaid plans. Also, this **plan** will not coordinate benefits with flexible spending accounts (FSA), health reimbursement accounts (HRA), or health savings accounts (HSA).

How Does Coordination Work?

When there are other sources that provide benefits, the plan that pays benefits first is called the primary plan. The plan that pays benefits next is the secondary plan.

When this plan is primary, it will pay the normal benefit. When this plan is secondary, it will use the maintenance of benefits method of coordination. With the maintenance of benefits method, this plan will first calculate benefits to see what it would have paid in absence of other coverage and then subtract that amount from the amount paid by the primary plan. In other words, the benefits of this plan will be maintained, even on a secondary basis. When this plan's payment would be greater than the primary plan's payment, this plan will pay the difference. This plan will never pay more than

it would have paid if it were the primary plan. If the primary plan and this plan would have paid the same amount, this plan will not make any additional payment.

Right To Receive And Release Necessary 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. This plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits under this plan and other plans covering the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply those rules and determine benefits payable.

How Does The Plan Coordinate Benefits When Multiple Preferred Provider Arrangements Are Utilized?

When both this plan, paying as secondary, and the primary plan have a preferred provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

Determining The Order Of Benefit Payments

The following applies when determining whether this plan will be primary or will pay benefits secondary to another plan:

- If the other source of coverage does not contain a coordination of benefits provision, that source always pays benefits first.
- If the **claimant** is covered by this plan as an **employee** and has coverage through another source as a dependent (e.g., your **spouse**'s plan), this plan is the primary plan and will pay benefits first. The other coverage, that provides benefits for the **claimant** as a dependent, will pay benefits second.
- If the **claimant** is covered by this plan as a **dependent spouse** and has coverage through another source as an **employee**, this plan is the secondary plan and will pay benefits second. The other coverage, which provides benefits for the **claimant** as an **employee** will pay benefits first.
- If the **claimant** is a child and is covered as a **dependent** under both this plan and the other parent's source of coverage, this plan will use the "birthday rule." The birthday rule means that the coverage of the parent whose birthday falls earlier in the year (regardless of the year of birth) is the primary plan and pays benefits first. The source providing coverage for the parent whose birthday falls later in the year pays benefits second. For example, if the mother's birthday is in June and the father's birthday is in August, the mother's source of coverage will pay benefits first. The age of the parent has no effect on whose coverage pays benefits first.
- If the **claimant** is a child, he or she is covered as a **dependent** under this plan and also the other parent's plan, and the other source of coverage uses the "gender rule," then this plan also uses the gender rule. The gender rule means that the father's source of coverage is primary and pays benefits first. The mother's source of coverage pays benefits second.
- If the **claimant** is a child of divorced or separated parents, the following order applies as to which source of coverage pays benefits first:
  - The parent who has financial responsibility for medical, **dental**, or other health care expenses due to a court order.
  - If the court order does not establish financial liability, the parent with physical custody pays first, then the **spouse** of the parent with physical custody, then the parent without physical custody and **spouse** of the parent without physical custody.
  - If neither of the above provisions establish which coverage is primary, the plan will use the birthday rule.
- If none of the above guidelines or the following charts apply, then the source providing coverage for the **claimant** longer pays benefits first.

Other Instances Where The Plan Coordinates Benefits With Other Coverages

This plan also coordinates benefits with other types of coverage, as shown in the following charts. If none of the below rules determine the order of benefits, the allowable expenses will be shared equally between the plans. This plan will not pay more than it would have paid had it been the primary plan.

If You Have...	**Here Is How This Plan Pays Benefits...**
Coverage through your former employer, but not as a **COBRA** continuant or retiree	This plan pays benefits second.
COBRA continuation coverage through a former employer	This plan pays benefits first.
Coverage through **Medicare** as the result of age (65 or older)	If your employer has less than 20 **employees**: **Medicare** pays benefits first and this plan pays benefits second (or third after **Medicare** and your spouse's employer's plan - if applicable). If your employer has 20 or more **employees**: This plan pays benefits first, **Medicare** pays benefits second (or third after your spouse's employer's plan - if applicable).
Retiree coverage through a former employer and you are not yet eligible for **Medicare**	This plan pays benefits first. Your former employer's retiree plan pays benefits second. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Retiree coverage through a former employer and you are eligible for **Medicare** (age 65 or older)	This plan pays benefits first. **Medicare** pays benefits second, and your former employer's retiree plan pays benefits third.
Coverage through **Medicare** as the result of end-stage renal disease	This plan pays benefits first and **Medicare** pays benefits second during the first 30 months of **Medicare** coverage. After 30 months, **Medicare** pays benefits first and this plan may or may not pay secondary benefits (depending on the amount **Medicare** pays).
Coverage through **Medicare** as the result of a disability	If your employer has less than 100 **employees**: If you are on a leave of absence and coverage continues during your leave, **Medicare** pays benefits first and this plan pays benefits second (or third after **Medicare** and your spouse's employer's plan - if applicable). If your employer has 100 or more **employees**: This plan pays benefits first as long as you are actively employed. If you are on a leave of absence and coverage continues during your leave, this plan pays benefits first, **Medicare** pays benefits second (or third after your spouse's employer's plan - if applicable).
Coverage through Medicaid	This plan pays benefits first, any other plan through which you have coverage pays benefits second, and Medicaid pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through another government-sponsored program (e.g., TRICARE)	This plan pays benefits first, any other plan through which you may have coverage pays benefits second, and the government-sponsored program pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage under this plan as a former **employee** through **COBRA**	This plan pays benefits second to any coverage provided through a plan covering you as an **employee** or dependent. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

Coverage through an employer, but not as a **COBRA** continuant or retiree	The other plan pays benefits first. If the other plan's payment is equal to or greater than the amount this plan would pay, this plan does not pay benefits. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** is eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If Your Child Has…	**Here's How This Plan Pays Benefits...**
Coverage under this plan through **COBRA**	This plan pays second to any coverage covering your child as a dependent. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through Medicaid	This plan pays first. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through another government-sponsored program (e.g., TRICARE)	Any other plan through which your child may have coverage pays benefits according to the priority previously described, and the government-sponsored program pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through **Medicare** as the result of end-stage renal disease	The plan responsible for your child's primary coverage (as previously explained) pays benefits first and **Medicare** pays benefits last during the first 30 months of **Medicare** coverage. After 30 months, **Medicare** pays benefits first, and the above rules governing the order of benefit payments apply next. This plan may or may not pay a benefit (depending on the amount any other plan and **Medicare** pay).

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** is eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If you or any member of your family has more than one source of coverage, contact the **Plan Supervisor** to get a complete understanding of how the COB feature applies.

How The Plan Coordinates With Automobile Insurance Coverage

This plan's liability for automobile accidents is based on the type of automobile insurance act or law enacted in your state.

You or your **dependents** are considered to be covered under an automobile insurance policy if you or your **dependents** are:

- an owner and principal named insured individual of the automobile insurance policy
- a family member or member of the household of the person who is insured by the automobile insurance policy
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this plan did not exist

Coverage under this plan will be secondary to any automobile coverage or personal **injury** protection coverage. Coverage provided by this plan is not intended to reduce the level of coverage that would normally be available through automobile insurance or personal **injury** protection coverage policy, nor does this coverage intend to provide benefits as primary in order to reduce any premium cost for automobile coverage or personal **injury** protection coverage.

If you or a **dependent** are involved in an automobile accident, all charges must be submitted to the automobile insurance. You will be asked to provide this plan with information concerning your automobile insurance or automobile coverage of any other party involved and information regarding all charges paid by any automobile coverage. This plan may, at its discretion, advance payment in order to prevent financial hardship. However, the plan will have an equitable lien against these parties up to the amount of the payment advanced. Please refer to the section titled "Reimbursement of Plan Payments" for further information.

IMPORTANT NOTE: If you live in a state that requires automobile coverage or personal **injury** protection coverage, and you fail to maintain coverage that is required by your state, you and/or your **dependents** will not be entitled to any benefits that would otherwise be payable by this plan.

No-Fault Automobile Insurance

In the event you or a covered **dependent** incur medical expenses as a result of an automobile accident, either as an operator or passenger of the vehicle or as a pedestrian, this plan has secondary liability for covered services, with payment limited to:

- any deductible under the automobile coverage
- any co-payment under the automobile coverage
- any expenses excluded by the automobile coverage that are covered plan benefits

Financial Responsibility Laws

Coverage under this plan will be secondary to any medical expense benefits available under your automobile insurance policy. If your state does not allow this plan to pay benefits as secondary or advance payment with the intent of subrogation, or recovering an overpayment, this plan will not cover any services related to an automobile accident for you or your **dependent**.

Coordination With Other Automobile Liability Insurance

If your state does not have no-fault automobile coverage or personal injury protection coverage or a "financial responsibility law," this plan will still be secondary and will coordinate payment for services with your automobile insurance coverage or with any other party who may have liability for medical expenses.

PARTICIPATING IN THE PLAN

Who Can Participate In The Plan?

You are eligible for coverage in this plan if you are regularly scheduled to work 30 hours per week as a **full-time employee** of the **company**.

Eligibility by Position. Any **employee** who is classified by the Employer as a working in a full-time position8 will be eligible to participate in the Plan upon the earlier of becoming classified by the Employer as working in a full-time position, or becoming eligible by measurement. Participation by reason of position will commence on the first day of the month following the completion of a 30-day waiting period after becoming classified as working in a full-time position, so long as the **employee** enrolls for coverage within the enrollment period established by the **plan administrator**, agrees and elects at the time and in the manner established by the **plan administrator** to pay the **employee**'s share of the cost for the tier of coverage selected by the **employee**, and satisfies any other conditions established by the **plan administrator** for enrollment in the Plan.

Eligibility by Measurement-**Ongoing Employee**

A. **Employee**s Determined to be Full-Time. An **Ongoing Employee** who is determined to be a **Full-Time Employee** during a **Standard Measurement Period** will be eligible to participate in the Plan during the **Standard Stability Period** associated with that **Standard Measurement Period**, so long as the **employee** enrolls for coverage within the enrollment period established by the **plan administrator**, agrees and elects at the time and in the manner established by the **plan administrator** to pay the **employee**'s share of the cost if any for the tier of coverage selected by the **employee**, and satisfies any other conditions established by the **plan administrator** for enrollment in the Plan.

B. **Employee**s Determined not to be Full-Time. An **Ongoing Employee** who is determined not to be a **Full-Time Employee** during a **Standard Measurement Period** will not be eligible to participate in the Plan during the **Standard Stability Period** associated with that **Standard Measurement Period**, unless the **employee** is eligible to participate by reason of the **employee**'s position.

Eligibility by Measurement-**New Employee**

A. New **Full-Time Employee**s. A **New Employee** who is reasonably expected at his or her **Start Date** to be a **Full-Time Employee** (and is not a **Seasonal Employee** or **Variable-Hour Employee**) will be eligible to participate in the Plan beginning on the first day of the month following the completion of a 30-day waiting period after the **employee**'s **Start Date**, so long as the **employee** enrolls for coverage within the enrollment period established by the **plan administrator**, agrees and elects at the time and in the manner established by the **plan administrator** to pay the **employee**'s share of the cost (if any) for the tier of coverage selected by the employee, and satisfies any other conditions established by the **plan administrator** for enrollment in the Plan.

1. Factors For Determining Full-Time Status. Although no single factor is determinative, the following factors may be relevant in determining whether a New **Employee** who is not a **Seasonal Employee** or **Variable-Hour Employee** is reasonably expected at his or her **Start Date** to be a **Full-Time Employee**:

    a) Whether the **employee** is replacing an **employee** who was (or was not) a **Full-Time Employee**.

    b) The extent to which Hours of Service of **Ongoing Employee**s in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent **Measurement Period**s.

    c) Whether the job was advertised or otherwise communicated to the **employee** or otherwise documented (for example, through a contract or job description), as requiring Hours of Service that would average 30 (or more) Hours of Service per week or less than 30 Hours of Service per week.

2. Transition to **Ongoing Employee**. Once a **New Employee** who is a **Full-Time Employee** has been employed for an entire **Standard Measurement Period**, the **employee** will become an **Ongoing Employee**, and the **employee**'s eligibility to participate in the Plan by reason of measurement will be governed by the provisions of this Article 3 regarding **Ongoing Employee**s.

B. New Non-Full Time **Employee**s

1. Full-Time After **Initial Measurement Period**. A **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee** will not initially be eligible to participate in the Plan (unless eligible by reason of position) and, instead, will have Hours of Service measured over an **Initial Measurement Period**.10 If such **employee** is determined to be a **Full-Time Employee** during the **employee**'s **Initial Measurement Period** based on the Hours of Service credited during the **Initial Measurement Period**, the **employee** will be eligible to participate in the Plan at the beginning of the **employee**'s **Initial Stability Period** and will remain eligible throughout the **employee**'s **Initial Stability Period**. To participate in the Plan during the **Initial Stability Period**, the **employee** must enroll for coverage within the enrollment period established by the **plan administrator**, agree and elect at the time and in the manner established by the **plan administrator** to pay the **employee**'s share of the cost (if any) for the tier of coverage selected by the **employee**, and satisfy any other conditions established by the **plan administrator** for enrollment in the Plan.

2. Not Full-Time After **Initial Measurement Period**. A **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee** who is determined not to be a **Full-Time Employee** during the **employee**'s **Initial Measurement Period** based on the Hours of Service credited during the **Initial Measurement Period** will not be eligible to participate in the Plan during the **employee**'s **Initial Stability Period**, except to the extent provided under the provisions regarding **Ongoing Employee**s or to the extent the **employee** is eligible for participation by reason of position.

3. Change in Status During **Initial Measurement Period**. Notwithstanding the foregoing, if a **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee** experiences a change in employment status before the end of the **employee**'s **Initial Measurement Period** such that if the **employee** had begun employment in that new status the **employee** would have reasonably been expected to be a **Full-Time Employee** (and not a **Seasonal Employee** or **Variable-Hour Employee**), the **employee** will be eligible to participate in the Plan beginning on the first day of the month following the completion of a 30-day waiting period after the change in the **employee**'s employment status (or, if earlier, at the beginning of the **employee**'s **Initial Stability Period**, if the **employee** is determined to be a **Full-Time Employee** during the **employee**'s **Initial Measurement Period**), so long as the **employee** enrolls for coverage within the enrollment period established by the **plan administrator**, agrees and elects at the time and in the manner established by the **plan administrator** to pay the **employee**'s share of the cost (if any) for the tier of coverage selected by the **employee**, and satisfies any other conditions established by the **plan administrator** for enrollment in the Plan.

4. Transition to **Ongoing Employee**. Once a **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee** has been employed for an entire **Standard Measurement Period**, the **employee** will become an **Ongoing Employee**, and the **employee**'s eligibility to participate in the Plan by reason of measurement will be governed by the provisions of this Article 3 regarding **Ongoing Employee**s, but subject to the following:

   a) If the **employee** is determined not to be a **Full-Time Employee** for the **Standard Measurement Period** that overlaps or immediately follows the **employee**'s **Initial Measurement Period**, the **employee** will remain eligible to participate in the Plan by reason of measurement during the entire **Initial Stability Period**, if the **employee** was determined to be a **Full-Time Employee** during the **employee**'s **Initial Measurement Period**.

   b) If the **employee** is determined to be a **Full-Time Employee** for the **Standard Measurement Period** that overlaps or immediately follows the **employee**'s **Initial Measurement Period**, the **employee** will be eligible to participate in the Plan during the entire **Standard Stability Period** associated with the **employee**'s first **Standard Measurement Period**, even though that **Standard Stability Period** may overlap an **Initial Stability Period** during which the **employee** is not eligible to participate in the Plan.

   c) If the **employee** is eligible to participate in the Plan during the **employee**'s **Initial Stability Period** and is eligible to participate in the Plan during the **employee**'s first **Standard Stability Period**, the **employee** also will be eligible to participate in the Plan during any period between the end of the **Initial Stability Period** and the beginning of the **employee**'s first **Standard Stability Period**.

When Can I Participate In The Plan?

As an eligible **employee**, you may participate in the plan described in this booklet on the first day of the month following 30 days from your date of full-time employment. Your Human Resources Department will provide you with an enrollment form.

How Do I Enroll For Coverage?

You must complete, sign and return your enrollment form to your Human Resources Department within 30 days from the date you become a **full-time employee** for you to be covered in this plan.

Can I Enroll My Spouse And Dependent Children?

Yes. If you enroll for coverage, you may also enroll your eligible **spouse** and **dependent** children.

Verification of **dependent** eligibility is required at the time of enrollment. Please be prepared to provide a federal income tax return, marriage certificate, birth certificate, or any other document required by the **Plan Administrator**.

Spouse and Dependent Eligibility-An **employee's spouse** and/or dependents who are otherwise eligible for coverage under the Plan [pursuant to the terms of the benefit description] [pursuant to the terms of the certificate of coverage] [as more fully described in this Section 3.514] will become eligible at the time the **employee** becomes eligible under this Article 3, subject to a timely election by the **employee** to obtain coverage under a coverage tier that includes the **spouse** and/or dependents.

How Do I Know If My Spouse Is Eligible?

Your **spouse** is eligible if you are legally married and neither legally separated nor divorced. This plan will not recognize common law marriages, whether or not such marriages are legal or valid under the laws of your state of residence or the state in which the ceremony occurred.

Can I Enroll My Domestic Partner?

Yes. You may enroll your eligible **domestic partner**. Please refer to the section titled "Glossary" for additional information regarding requirements.

What If Both My Spouse And I Work For The Company?

If both you and your **spouse** are eligible for coverage as **employees** under this plan, only one of you may enroll all members of your family as **dependents**.

If both you and your **spouse** are **employees** and one of you becomes ineligible for coverage, the one who remains eligible as an **employee** may within 30 days cover their **spouse** as a **dependent** and may cover any children who were covered under the **spouse**'s coverage.

See questions "Can I Enroll Myself And/Or My Dependents If I Previously Declined Participation In The Plan?" and "Can I Change My Coverage During The Year?" for more information.

How Do I Know If My Dependent Children Are Eligible?

If you enroll for coverage, you may also enroll your eligible **dependent** children. Please refer to the chart below for eligibility requirements:

Eligible dependents	Requirement
Your **dependent** children	Your children up to the end of the month of their 26th birthday. Children are your: • natural born children, • step children, • legally adopted children, • children for whom you have court appointed guardianship, • foster children, • children under age 18 who have been placed for adoption, whether or not the adoption is final. Proof of adoption or placement for adoption is required for enrollment in the plan.
Totally disabled children	Your unmarried children who are **totally disabled** either mentally or physically may continue their participation in the plan after they reach age 26 provided they were enrolled in the plan at the end of the pay period in which they reached age 26. Proof of their incapacity must/may be provided. Coverage will end when the child is no longer **totally disabled**.
QMCSO	This plan will also provide coverage as described by a **Qualified Medical Child Support Order (QMCSO)** that assigns the rights of a participant or beneficiary to receive benefits under this health plan.

What If A Court Order Requires That I Provide Coverage For My Dependent Child?

A **Qualified Medical Child Support Order (QMCSO)** is a court decree under which a court mandates coverage for a child (called an **alternate recipient**). Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the **Plan Administrator** shall take the following steps, within 20 business days:

1. Determine if the notice or order conforms to the requirements of a QMCSO,
2. Reply to the issuing agency if you are no longer employed, fall into a class of **employees** who are ineligible for coverage or if **dependent** coverage is not provided,
3. Notify the issuing agency if the notice or order is determined to not meet the requirements of a QMCSO,
4. Notify the issuing agency of the coverage options available under the plan and any waiting periods which exist for coverage under the plan (if applicable),
5. Determine if federal withholding limits or prioritization rules permit the withholding from your income of the amount required to obtain coverage for the children specified,
6. If appropriate, withhold from your income any contributions required,
7. Notify you of any contributions to be withheld from future pay,
8. Notify **Plan Supervisors**/vendors about enrollment, and
9. Notify the issuing agency of the date of enrollment and date coverage under the plan will begin.

The participant and each **alternate recipient** shall have the right to request in writing that the **Plan Administrator** re-review the status of the notice or order. The request must be submitted within 60 days after being notified of the **Plan Administrator's** decision. The participant and each **alternate recipient** may present additional materials to the **Plan Administrator** for review. The **Plan Administrator** may request additional information or material from the participant or **alternate recipient**. The **Plan Administrator** must provide sufficient information to understand available options and to assist in appropriately completing the notice or order.

Who Would Not Be Considered Eligible For Enrollment In This Plan?

- You and your **dependents**, on the date your employment terminates or the date you no longer meet eligibility requirements as defined in this plan.
- Your **spouse** beginning on the date you are legally divorced or legally separated.
- Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under Federal law.
- Any individual who does not meet the definition of an **employee** or **dependent**.
- Domestic partners.

NOTE: If your coverage terminates or if a **dependent** ceases to be covered for any of the above reasons, you and/or your **dependent** may be eligible to continue coverage under the plan.

What Is My Cost To Participate In The Plan?

The **company** shares in the cost of coverage for you and your eligible **dependents**. Information regarding the specific cost for coverage can be obtained from your Human Resources Department.

Employee's Share of the Cost of Coverage-The Employer will determine from time to time, in its sole discretion, the amount (if any) an **employee** will be required to contribute toward the cost of coverage for the tier of coverage selected by the **employee** under the Plan.

Can I Enroll Myself And/Or My Dependents If I Previously Declined Participation In The Plan?

If you are an eligible **employee**, you may have the opportunity to enroll yourself and **dependents** at open enrollment. During this time, you will have an opportunity to select the coverage that is best for your family. The **annual open enrollment period** will be determined and announced each year by the **company**. You may enroll for benefits and change the eligible **dependents** you cover. Elections made during the **annual open enrollment period** will be effective on October 1st.

If you declined enrollment for yourself or your **dependents** and you or your **dependents** become eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP), you may enroll yourself and **dependents** in this plan within 60 days of when eligibility for the subsidy was determined.

If you declined enrollment for yourself or your **dependents** and coverage under Medicaid or Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you may enroll yourself and **dependents** in this plan within 60 days of the loss of coverage.

If you declined enrollment for yourself or your **dependents** because you or your **dependents** have other group coverage or another health insurance arrangement, you may, in the future, be able to enroll yourself or your **dependents** in this plan, provided you request enrollment within 30 calendar days after your other coverage ends.

In order to enroll, you must have indicated at the time you and/or your **dependents** were eligible for enrollment that the reason coverage was waived was due to other coverage. If the other coverage was not provided under a **COBRA** continuation provision, that coverage must have terminated either as a result of loss of eligibility or because employer contribution to that coverage has ceased. If the other coverage was provided under a **COBRA** continuation provision, the maximum **COBRA** continuation period must be exhausted. Proof of loss of coverage must be provided.

What Information Do I Need To Enroll During The Year?

If you have a new **dependent** as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your **spouse** and your **dependent** child, provided you request enrollment within 30 calendar days after the marriage, birth, adoption or placement for adoption. You must provide your Human Resources Department with the following information in writing and provide written documentation of the event (i.e., birth certificate, marriage license, etc.) within that 30 calendar day period:

1. The reason for the addition (e.g., newborn baby, adoption, marriage, etc.)
2. The name of each **dependent**
3. Their relationship to you
4. Their dates of birth
5. The date they became your **dependents** (e.g., newborn baby – date of birth; adoption – date of adoption; marriage – date of marriage)
6. Their social security number

If you add your **dependents** within the 30-day period specified above, their coverage will be effective, as of the dates they became your **dependents**. If they are not added at that time, they may only be added as described above.

Are There Other Changes I Need To Provide To My Human Resources Department?

To keep your coverage up-to-date, you should notify your Human Resources Department immediately whenever your personal status or that of your **dependents** changes in such a way as to affect your coverage. Typically changes of this sort occur when:

- you move,
- you marry,
- you have a child,
- you are divorced,
- a covered **dependent** becomes ineligible, and
- there is a change in your **spouse**'s or **dependent's** health coverage.

Can I Change My Coverage During The Year?

IRS regulations require that your benefit elections remain in effect throughout the full **plan year** (January 1 – December 31). The only exception that permits you to change your election during the year is when you experience a qualified change in family status. When you do experience a qualified change in family status based on the chart below, the mid-year election changes must be consistent with the following requirements:

- The event must cause you or your **dependent** to gain or lose eligibility for:
  - benefits under one of the benefit plans;
  - benefits available through the cafeteria plan; or
  - benefits available under another employer's benefit plan or plan option.
- The mid-year election change must be "on account of" the change in status; and
- The mid-year election change must "correspond with" the change in status that caused a gain or loss of plan eligibility.

The following chart explains which events are considered qualified changes in family status and what changes you may make as a result.

Event	Enrollment Procedure
Change in marital status	You may add your **spouse** and children, drop coverage or change coverage as a result of marriage. You may delete **spouse**/add **dependents** due to a divorce, legal separation or annulment. You may delete **spouse**/add **dependents** or change coverage due to the death of a **spouse**.
Change in number of **dependents**	You may add your children/**spouse** or change coverage as a result of a birth, adoption or placement for adoption. You may delete **dependent**/change coverage due to a death of a **dependent** child.
Change in employment status or work schedule of the **employee**, **spouse** or **dependent**	You may drop coverage/add coverage, delete **spouse** or **dependent** or change coverage as the result of commencement or termination of employment, change in worksite, commencement or return from leave of absence, change from part-time to full-time employment or vice-versa, or change from salaried to hourly pay.
Significant change in coverage or in cost of coverage	You may drop coverage/add coverage or change coverage if the change in coverage or in cost of coverage affects eligibility under another group health plan for you or your **spouse** due to your **spouse**'s employment.
Change in residence of the **employee**, **spouse** or **dependent**	You may drop coverage or change coverage if you move out of the coverage area, provided the move causes you or your **dependent** to gain or lose eligibility.
Dependents gain or lose eligible status	You may add/drop coverage of a **dependent** that is meeting or ceasing to meet the plan's definition of **dependent**, such as attainment of a specified age.
Mid-year eligibility for or loss of **Medicare** or Medicaid	You may add/drop coverage or delete **dependent** as a result of gain or loss of **Medicare** or Medicaid coverage.
A judgment, decree or order requiring **dependent** coverage (e.g., QMCSO)	You may add coverage and **dependent** child due to a judgment, decree or order requiring **dependent** coverage.

What Should I Do If I Experience A Family Status Change?

If you have a qualified change in family status, please contact your Human Resources Department immediately so that they can provide you with the information you will need to make any changes allowed under this plan. You must make these changes within 30 days of the event.

When Will My Coverage And/Or My Dependents Coverage End?

Your coverage

Your coverage will end when any of the following occur:

- the day you are no longer an eligible **employee**,
- the day you stop making required contributions,
- the day you decline coverage,
- the day you leave employment at the **company**,
- the day you retire,
- the day the plan is terminated, or is amended such that you do not meet the requirement for coverage under the plan,
- the day you commit an act of fraud or intentional misrepresentation of a material fact.

Your dependent's coverage

Coverage for your **dependents** will end when any of the following occur:

- the day your coverage ends,
- the day your **dependent** no longer meets the plan's requirement of an eligible **dependent** (Please refer to the section titled "How Do I know If My Dependent Children Are Eligible" for eligibility requirements)
- the day you stop making required contributions,
- the day you decline coverage for your eligible **dependents**,
- the day you retire,
- the day the plan is terminated, or is amended such that you or your **dependent** do not meet the requirement for coverage under the plan,
- the day you or your covered **dependent** commit an act of fraud or intentional misrepresentation of a the day material fact.

When coverage ends for you and your covered **dependents** as provided above, you and/or your covered **dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to the section titled "Continuation Coverage."

In certain circumstances your coverage may be extended. These situations are described in the following few questions.

What Happens To My Coverage If I Go On Medical Leave?

Coverage for you and your covered **dependents** will continue for up to three months (up to six months under certain narrow criteria) from the date your approved work related or non-work related medical leave of absence began. During this time, you must continue to pay your share of any contribution required. If you should have any Family and Medical Leave Act (FMLA) leave entitlement remaining, this approved leave time will count towards your FMLA leave entitlement.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage." The time between the **COBRA** event date and the date coverage ends is considered part of the time of coverage allowed under **COBRA**.

What Happens To My Coverage If I Am Laid Off?

Coverage for you and your covered **dependents** will end at midnight of your last day worked.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage." The time between the **COBRA** event date and the date coverage ends is considered part of the time of coverage allowed under **COBRA**.

What Happens To My Coverage If I Take A Personal Leave Of Absence?

Your coverage and that of your covered **dependents** will continue for up to one year from the date your personal leave of absence began. During this time, you must pay the entire cost of coverage. This portion of your leave is also included in the maximum period of continued coverage allowed under "Continuation Coverage".

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage." The time between the **COBRA** event date and the date coverage ends is considered part of the time of coverage allowed under **COBRA**.

What Happens To My Dependents' Coverage If I Pass Away?

Coverage for your covered **dependents** will continue until the end of the month in which your death occurred. Your **dependents** must pay the regular contribution for coverage.

Your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage." The time between the **COBRA** event date and the date coverage ends is considered part of the time of coverage allowed under **COBRA**.

Cessation of Participation-In general, an eligible **employee** (and the **employee**'s **spouse** and/or dependents, as applicable) will cease to participate in the selected coverage under this Plan as of the earliest to occur of the following:

A. On the last day of any Stability Period after which the **employee** ceases to be eligible for coverage under the Plan by reason of measurement, so long as the **employee** does not continue to be eligible by reason of position.

B. In the case of a **New Employee** who is a **Full-Time Employee** who has not reached the **employee**'s first **Standard Stability Period**, on the last day of the month in which the **employee** is credited with at least 130 Hours of Service, so long as the **employee** does not continue to be eligible by reason of position.

C. In the case of an **employee** to whom this paragraph applies,16 on last day of the third calendar month after the change in employment status described in this paragraph, so long as the **employee** does not continue to be eligible by reason of position. This paragraph applies to an **employee** if:

1. The Employer has offered the **employee** minimum value17 coverage continuously during the period beginning on the first day of the calendar month following the **employee**'s initial three full calendar months of employment and ending on the last day of the calendar month in which the change in employment status described in this paragraph occurs;

2. The **employee** has a change in employment status to a position or status in which the **employee** would not have reasonably been expected to be a **Full-Time Employee** if the **employee** had begun employment in that position or status; and

3. The **employee** actually is credited with less than 130 Hours of Service for each of the three full calendar months following such change in employment status.

D. On the last day of the month in which the **employee** ceases to be eligible for coverage by reason of position, so long as the **employee** does not continue to be eligible for coverage by reason of measurement.

E. On the last day of the month in which the **employee**'s employment terminates.

F. On the last day of the month for which the **employee** has paid the **employee**'s required share of the cost of coverage under the Plan.

G. On any other date that the **employee** ceases to satisfy the eligibility requirements of this Plan.

H. On the date the Plan terminates.

What If I Return To Work From My Medical Leave, Personal Leave Of Absence Or Layoff?

If you elect "Continuation Coverage", and you return from a layoff, medical/personal leave of absence, coverage for you and your eligible **dependents** will begin on the day you return to active employment. Amounts previously credited toward a plan **deductible** (same calendar year) will be carried forward.

If you elect "Continuation Coverage", and you are rehired, coverage for you and your eligible **dependents** will begin as stated in the section titled "Participating in the Plan", question "When Can I Participate in the Plan?" Unless the **employee** was credited with an **hour of service** with the employer for a period of at least 13 consecutive weeks, immediately preceding date of hire.
Amounts previously credited toward a plan **deductible** will not be carried forward.

If you do not elect "Continuation Coverage", and you return from a layoff, a medical or personal leave of absence or are rehired, coverage for you and your eligible **dependents** will begin as stated in the section titled "Participating in the Plan", question "When Can I Participate in the Plan?" Amounts previously credited toward a plan **deductible** will not be carried forward.

Do I Have Continuation Rights Under USERRA If I Am On Military Leave?

You may elect to continue coverage under the plan (including coverage for **dependents**) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with the **company** under the Uniformed Services Employment and Reemployment Rights Act of 1994). If your period of military service is less than 31 days, you will be required to pay your normal contributions for coverage. If your period of military service is 31 days or more, your contributions for the continued coverage shall be the same as for a **COBRA** beneficiary.

Whether or not you continue coverage during military service, you may reinstate coverage under this plan upon your return to employment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. The reinstatement will be without any waiting period otherwise required under the plan, except to the extent that the waiting period would have been imposed if coverage had not terminated due to military service. This waiver of the waiting period shall not apply to any **illness** or **injury** that is incurred in, or aggravated during, the performance of military service.

Do I Have Continuation Rights Under FMLA If A Member Of My Family Is On "Covered Active Duty" Or Is A "Covered Service Member?"

The Family Medical Leave Act of 1993 (FMLA), as amended, provides rights to certain family members of **employees** who are individuals in the service of the United States Armed Forces. These benefits include the extension of health benefits and the resumption of benefits upon return from the leave. You are a qualified **employee** if:

- You have worked for the **company** for at least 12 months, and
- You have worked for at least 1,250 hours during the year preceding the start of the leave, and
- Your spouse, son, daughter or parent has been called to active duty in the Armed Forces of the United States (including the National Guard). This is called "qualifying exigency leave", or

- You are the spouse, parent, son, daughter or next of kin of a service member who is undergoing medical treatment, recuperation or therapy for an **injury** or **illness** incurred in the line of active duty in the Armed Forces (including the National Guard) that renders the service member medically unfit to perform his or her duties. This is called "service member care leave."

A qualified **employee** is entitled to up to 12 weeks of "qualifying exigency leave" in a 12 month period. This 12 week period will be measured looking back 12 months from the date leave is first used.

A qualified **employee** is entitled to up to 26 weeks of "service member care leave" in a 12 month period. This 26 week period will be measured looking back 12 months from the date leave is first used.

Please see the question titled "What Happens to My Coverage If I Take a Leave under the Family and Medical Leave Act (FMLA) (For a Reason Other Than Military Leave)?" for a description of contributions that will be required during FMLA leave and other FMLA provisions.

What Happens To My Coverage If I Take A Leave Under The Family And Medical Leave Act (FMLA) (For A Reason Other Than Military Leave)?

The Family and Medical Leave Act of 1993 (FMLA) provides certain rights to qualified **employees**. Included in these rights are certain provisions regarding the extension of health benefits and the resumption of benefits for **employees** who are granted leave. You are a qualified **employee** if:

- You have worked for the **company** for at least 12 months,
- You have worked for at least 1,250 hours during the year preceding the start of the leave, (and)
- You are at a worksite where the **company** employs at least 50 **employees** within a 75 mile radius.

A qualified **employee** is entitled to leave under the FMLA for:

- Birth of a child and to care for such child (up to 12 months after the birth of the child).
- Placement of a child for adoption or foster care (up to 12 months after the placement of the child).
- Care of your seriously ill spouse, child or parent.
- A serious health condition that makes you unable to perform your job functions.

A qualified **employee** is entitled to up to 12 weeks of leave in a 12 month period under the FMLA. The 12 month period will be measured looking back 12 months from the date leave is used. During the time an **employee** is granted leave under the FMLA you must pay your regular contribution for coverage for you and your covered **dependents**. Your contribution must be paid by a system voluntarily agreed to by you and the **company**, including increased payroll deductions to prepay contributions if the need for leave is foreseeable.

You will be allowed a 30 day grace period from the due date to make the premium payment. If payment is not made during that time, your coverage will be suspended when the grace period ends. If you fail to pay a contribution during your leave, coverage will be suspended. Coverage will resume, when you return to work, as though it had not been lost and no waiting period will be imposed.

If your coverage ends due to failure to pay a required premium or if you do not return to work, you and/or your covered **dependents** may continue coverage as provided under **COBRA**. The maximum **COBRA** coverage period begins on the last day of your FMLA leave, the qualifying event date.

GLOSSARY

Whenever one of the following words or phrases appears highlighted, they shall have the meaning explained below, unless the context requires otherwise. Please note, "**reasonable and customary**," "**experimental**," "**investigational**," and "**medically necessary**" have been defined elsewhere in this **SPD**.

Administrative Period: a **Standard Administrative Period** or an **Initial Administrative Period**.

Adverse benefit determination: a rescission of coverage or a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a participant's or beneficiary's eligibility to participate in the plan. This includes a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review (if applicable), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental** or **investigational** or not **medically necessary** or appropriate.

Affordable Care Act (ACA): is a United States Federal statute signed into law on March 23, 2010. It represents the most significant government expansion and regulatory overhaul of the United States healthcare system since 1965.

Alternate Recipient: any child of a participant in a group health plan who is recognized under a Medical Child Support Order as having a right to enrollment under the plan with respect to such participant.

Annual open enrollment period: an annual period each fall, during which you may enroll into the plan for benefits to be effective on the following January 1. The enrollment period will be determined and announced each year by the **employer**. Please contact the Benefits Department (or HR) for further information.

Authorized representative: a **physician** rendering the service for which a bill is submitted (but not a designee of the **physician**), or a person who a covered **employee** or covered **dependent** has authorized in writing to act on his/her behalf. If the claim is an urgent care **pre-service claim**, the plan will consider a **health care professional** with knowledge of a **claimant's** medical condition as an **authorized representative**.

If a covered **employee** or covered **dependent** wishes to authorize another person (e.g., family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the **Plan Administrator** of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from your Human Resources Department.

Certified Nurse Midwife: a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) who has completed a course of study and has been certified and licensed as a midwife.

Claimant: an eligible **employee**, a covered **dependent** or an **authorized representative**.

Claims Administrator: your plan has different **Claims Administrators** based on the type of claim. The **Claims Administrator** for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an **adverse benefit determination**. Each is independently responsible for notifying you of the **adverse benefit determination**, based on the type of claim, as well as reviewing any appeal you may make.

Your **Claims Administrators** are as follows:

Pre-service claims:

Medical: NGS CoreSource, P.O. Box 2310, Mt. Clemens, MI 48046, (800) 521-1555.

Post-service claims:

Medical: NGS CoreSource, PO Box 2310, Mt. Clemens, MI 48046, (800) 521-1555.

Pharmacy: CVS Caremark, 750 W. John Carpenter Freeway, Suite 600, Irving, TX 75039, (866) 818-6911.

Each **Claims Administrator** shall have final discretionary authority to construe the terms of the plan, for purposes of final claims determinations, for those claims listed above for which they are designated as the **Claims Administrator**.

COBRA: the Consolidated Omnibus Budget Reconciliation Act of 1986 that requires group health plans to provide **employees** and eligible family members the opportunity to continue health care coverage at their own expense, when coverage would be lost under certain circumstances.

Company: Gunnison County, Colorado 200 E. Virginia Avenue, Gunnison, CO 81230, (970) 641-7623.

Concurrent claims decision: a decision by the plan relating to an ongoing course of treatment.

Concurrent hazardous medical condition: a potentially life-threatening condition, substantiated by the patient's attending **physician**, requiring care with immediate access to **hospital** equipment. (For the purpose of **hospital confinement** for **dental** procedures, conditions such as hemophilia, uncontrollable diabetes and hypertension will be considered **concurrent hazardous medical conditions**.)

Congenital defect: a physical abnormality existing at birth.

Controlled or Affiliated Group: the group of organizations consisting of the Plan Sponsor and any other organization that is part of a controlled group or affiliated service group.

Covered individual: an eligible **employee**, **covered spouse** or **dependent** that is enrolled in the Gunnison County, Colorado Employee Medical Benefit Plan. (This includes only those people who qualify for enrollment as indicated in the section titled “Participating in the Plan.”)

Covered spouse: the **employee's** current legally married husband or wife who is enrolled in the Gunnison County, Colorado Employee Medical Benefit Plan. (This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan.")

Deductible: a specific dollar amount that a **covered individual** must pay (or "satisfy") in covered expenses each calendar year before the plan pays its share of covered expenses. (Please refer to the section titled "What is the Plan **Deductible**?" for further information.)

Dental: relating to the teeth or gums.

Dentist(s): 1) a legally licensed Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) practicing within the scope of his/her license who is permitted to perform services for which coverage is provided in this plan. 2) a legally licensed **physician** authorized by his/her license to perform the particular **dental** procedure for which coverage is provided in this plan.

Dependent: people who have a relationship to an **employee**. This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan."

Diagnosis: a descriptive statement of a medical or **dental** condition.

Educational program: a training or **educational program**, typically offered in a group setting designed to instruct in the management of a medical condition.

Emergency: an accidental **injury**, or the sudden onset of an **illness** where the acute symptoms are of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the **covered individuals** life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Emergency services: with respect to the treatment of an **emergency**, a medical screening examination, including ancillary services to evaluate the **emergency** and such further medical examination and treatment required to stabilize the patient.

Employee: an individual who is regularly scheduled to work 30 hours per week as a **full-time employee** of the **company**.

Employer: means the Plan Sponsor and any other member of the **Controlled or Affiliated Group** that has adopted this Plan for the benefit of the Employer's **employees**.

Enrollment date: the earlier of the date your coverage begins or the date your waiting period for coverage begins. For a late enrollee, the **enrollment date** is the first day of coverage.

Essential health benefits: those benefits identified by the U.S. Secretary of Health and Human Services and include benefits for covered expenses incurred for the following services:

1. ambulatory patient services;
2. **emergency services**;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment (mental and nervous disorder and chemical dependency);
6. **prescription drugs**;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management;
10. pediatric services, including oral and vision care.

Full-Time Employee: means, with respect to a calendar month or a **Measurement Period**, an **employee** of the Employer who is employed an average of at least 30 Hours of Service per week. For this purpose, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.

Habilitative therapy: healthcare services that help a **covered individual** keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of **inpatient** and/or **outpatient** settings.

Health care professional: a **physician** or other **health care professional** licensed, accredited, or certified to perform specified health services consistent with state law.

Home health care agency: a public or private agency legally operating in the state in which it is located, that provides nursing services administered in a person's home by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or by a home health aide who is employed by the **home health care agency**.

Hospice: a health care program providing a coordinated set of services rendered at home, in **outpatient** settings or in institutional settings for **covered individuals** suffering from a condition that has a terminal prognosis. A **hospice** must have an interdisciplinary group of personnel that includes at least one **physician** and one Registered Nurse (RN), and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital: an **inpatient** institution or **inpatient** facility that meets all of the following requirements set forth (A), (B) or (C) below:

A
- It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to **hospitals**.
- It is open at all times.
- It provides diagnostic services and therapeutic services and organized facility for **surgery** on the premises for the surgical and/or medical treatment of ill and injured persons.
- The treatment is by or under the direct supervision of licensed **physician(s)** or surgeon(s) specializing in the treatment rendered.
- The facility continuously provides 24-hour nursing services by Registered Nurses (RN).
- It is not - other than incidentally - a place for rest, for the aged, for alcoholics, for drug addicts, for pulmonary tuberculosis or a nursing home.

B
- When used in conjunction with **inpatient** confinement for mental and nervous disorders or chemical dependency, it will include an institution which is licensed as a mental **hospital** or chemical dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

C
- It is an **inpatient** facility that provides restorative services to **inpatients** under the direction of a **physician** knowledgeable and experienced in rehabilitative medicine and is licensed and operated in accordance with the laws of the jurisdiction in which it is located.

Hospital confinement: the period of time an individual spends in a **hospital** as an overnight bed patient (**inpatient**).

Hour of Service: means (1) each hour for which an **employee** is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an **employee** is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, **illness**, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

1. The term **Hour of Service** does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code Sections 861 through 863 and the regulations thereunder.

2. An **Hour of Service** for one organization is treated as an **Hour of Service** for all other organizations that are part of the same **Controlled or Affiliated Group** for all periods during which those organizations are part of the same **Controlled or Affiliated Group**.

3. Hours of Service for all **employee**s are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due.

Illness: the condition of being sick or unhealthy as classified in the current International Classification of Diseases (ICD).

Infertility: the inability or diminished ability to produce offspring.

Initial Administrative Period: means, with respect to a **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee**, an **Administrative Period** consisting of all periods between the **employee**'s **Start Date** and the beginning of the **employee**'s **Initial Stability Period** other than the **employee**'s **Initial Measurement Period**.

Initial Measurement Period: means, with respect to a **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee**, the 12-month period beginning on the first day of the calendar month following or coincident with the **employee**'s **Start Date**.

Initial Stability Period: means, with respect to a **New Employee** who is a **Part-Time Employee**, **Seasonal Employee**, or **Variable-Hour Employee**, except as provided in Section 3.4.B.4., the 12-month period beginning on the first day of the second calendar month after the end of the **Initial Measurement Period**.

Injury: a sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact. Strains and spasms are considered an **illness** rather than an **injury**.

Inpatient: an individual who is officially admitted to a **hospital** as a bed patient and occupies a **hospital** bed a minimum of 18 hours while receiving **hospital** care, which includes room, board and general nursing care.

Learning disability: inability or defect in ability to learn. Typically this occurs in children and is manifested by difficulty in learning basic skills such as writing, reading and mathematics.

Look-Back Measurement Method: means the method of identifying **Full-Time Employee**s for purposes of Code Section 4980H that is described in Treas. Reg. 54.4980H-3(d), as amended or supplemented.

Measurement Period: means an **Initial Measurement Period** or a **Standard Measurement Period**.

Medicare: a Federal program through the Social Security System that provides benefits for **hospital** and **physician** care. This includes a Health Maintenance Organization (HMO) that participates with **Medicare** and receives payment from **Medicare**. (It is available on an enrollment basis to individuals receiving dialysis treatment beyond 30 months, individuals eligible for Social Security benefits if they are age 65 or older or those individuals who have qualified for Social Security disability benefits and have received such disability benefits for 24 months.)

Mental disorder: a clinically significant behavior or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function and requires psychiatric care for any reason, or an organic or biological condition which requires psychiatric care for any reason.

Network provider: a facility or practitioner who has a signed, effective contract with a preferred provider network to provide medical services at a specific rate or pay. Please contact your Human Resources Department for further information.

New Employee: means an **employee** who has been employed for less than one complete **Standard Measurement Period**.

Non-network provider: a facility or practitioner who does not have a signed, effective contract with a preferred provider network.

Nurse: a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Licensed Vocational Nurse (LVN) who provides nursing care.

Occupational therapist: a **health care professional** licensed, accredited, registered or certified to perform occupational therapy consistent with state law.

Ongoing Employee: means an **employee** who has been employed for at least one complete **Standard Measurement Period**

Out-of-pocket maximum: the maximum amount of out-of-pocket expenses you have to pay each calendar year for certain covered medical expenses. (Please refer to the section titled "What is your **Out-Of-Pocket Maximum**?" for further information.)

Outpatient: an individual who receives medical care, treatment, services or supplies at a clinic, **physician's** office or at a **hospital** if not a registered bed patient at that **hospital**.

Part-Time Employee: means a **New Employee** whom the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the **employee**'s **Initial Measurement Period**, based on the facts and circumstances at the **employee**'s **Start Date**. Although no single factor is determinative, the following factors may be relevant in determining whether a **New Employee** is a **Part-Time Employee**:

1. Whether the **employee** is replacing an **employee** who was (or was not) a **Full-Time Employee.**
2. The extent to which Hours of Service of **Ongoing Employee**s in the same or comparable positions have varied above and below an average of 30 hours of service per week during recent **Measurement Period**s.
3. Whether the job was advertised or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description), as requiring hours of service that would average 30 (or more) hours of service per week or less than 30 hours of service per week.

The anticipated length of the **Employee**'s **Period of Employment** shall not be considered.

Period of Employment: means the period of time beginning on the first date for which an **employee** is credited with an **Hour of Service** for an Employer or any member of the **Controlled or Affiliated Group** and ending on the last date on which the **employee** is credited with an **Hour of Service** for that Employer or any member of the **Controlled or Affiliated Group**, both dates inclusive. An **employee** may have one or more Periods of Employment with the same Employer.

Physical therapy: physical evaluation (including muscle testing) for a **covered individual** and certain therapeutic treatments professionally administered by a **physical therapist** or a **physician**, to aid in the recovery from **illness** or **injury**, including - but not limited to - diathermy, gait training, hot or cold packs, manual traction, massage, mechanical traction, prosthetic training and whirlpool. **Physical therapy** activities are designed to help the **covered individual** attain greater self-sufficiency, mobility and productivity through exercises and externally applied heat, electroshortwave, hydrotherapy and other mechanical modalities intended to improve muscle strength, joint motion, coordination and general endurance.

Physical therapist: a **health care professional** licensed, accredited, registered or certified to perform **physical therapy** consistent with state law.

Physician: a qualified Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Chiropractic (DC), a Doctor of Podiatry (DPM), a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD), a Doctor of Optometry (OD), a Psychologist (PhD) and other **health care professionals**, who, within the scope of their license in the state in which they practice, are legally permitted to perform services for which coverage is provided in this plan.

Plan Administrator: Gunnison County, Colorado 200 E. Virginia Avenue, Gunnison, CO 81230 (970) 641-7623.

Plan Document: the legal description of and the governing document for this plan.

Plan Supervisor: NGS CoreSource, P.O. Box 2310, Mt. Clemens, MI 48046, (800) 521-1555.

Plan year: begins on the first day of January and ends on the last day of the following December.

Post-service claim: any claim for a benefit under this plan that is not a **pre-service claim**. In other words, a claim that is a request for payment under the plan for covered services that a **claimant** has already received.

Prescription drug: those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a **physician** or **dentist** and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

Pre-service claim: any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- **Urgent Care Claim:** A **pre-service claim** may be an urgent care claim if it is for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **claimant**; or jeopardize the ability of the **claimant** to regain maximum function; or in the opinion of a **physician** with knowledge of the **claimant's** medical condition, would subject the **claimant** to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim and the plan conditions receipt of the benefit for the service, in whole or in part, on approval in advance of obtaining medical care.

A **health care professional** with knowledge of the **claimant's** medical condition may determine if a claim is one involving urgent care. If there is no such **health care professional**, an individual acting on behalf of the plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, may make the determination.

- This plan does not condition benefit payment whether an urgent care claim or a non-urgent care claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, NGS CoreSource, P.O. Box 2310, Mt. Clemens, MI 48046, or by calling (800) 521-1555.

Primary care physician (PCP): providers in the following areas of medical practice: General Practice, Family Practice, Pediatrics, Internal Medicine, and Obstetrics and Gynecology.

Psychiatrist: a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who specializes in the study and treatment of **mental disorders** and psychological diseases.

Psychologist: a licensed individual who is usually a Ph.D. and is trained in methods of psychological analysis, therapy and research for treatment of psychological and psychoneurological disorders.

Qualified Medical Child Support Order (QMCSO): an order of a court or authorized administrative agency requiring medical child support which meets the federal law requirements to be a **Qualified Medical Child Support Order**.

Reliable scientific evidence:

- Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
- Peer reviewed literature, biomedical compendia, and other medical literature that meet MCCN guidelines or the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, or MEDLARS database Health Services Technology Assessment Research (STAR).

Required preventive care:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), except for annual mammogram benefits as specified below;
2. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations; and
3. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age 6; children and adolescents aged 7 through 18 years and adults 19 years and older.

Seasonal Employee: means a **New Employee** who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year.

Skilled nursing facility: a facility approved by **Medicare**, which is primarily engaged in providing 24-hour skilled nursing and related services on an **inpatient** basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of **physicians**. A **skilled nursing facility** is not, other than incidentally, a place that provides:

- minimal care, **custodial care**, ambulatory care or part-time care services; or
- care or treatment of **mental disorders**, substance abuse, alcoholism, drug abuse or pulmonary tuberculosis.

Special Unpaid Leave: means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

Speech therapist: a **health care professional** licensed, accredited, registered or certified to perform speech therapy consistent with state law.

Spouse: a husband or wife as defined, or recognized under state law for purposes of marriage in the state where the **employee** resides, including same-sex marriage.

Stability Period: means a period selected by the Employer that follows, and is associated with, a **Standard Measurement Period** or an **Initial Measurement Period**.

Standard Administrative Period: means a 61-day period beginning on November 1 each year and ending on the following December 31.

Standard Measurement Period: means the 12-month period beginning on November 1 each year and ending on the following October 31.

Standard Stability Period: means a 12-month **Stability Period** beginning on January 1 each year and ending on the following December 31.7 The same **Standard Stability Period** applies with respect to **Employees** who are determined to be **Full-Time Employee**s during the **Standard Measurement Period** and **Employees** who are determined not to be **Full-Time Employee**s during the **Standard Measurement Period**.

Start Date: means the first date on which an **employee** is credited with an **Hour of Service** with the Employer.

Summary Plan Description (SPD): this summary of your benefits.

Surgery: a cutting operation, suturing of a wound, treatment of a fracture, relocation of a dislocation, radiotherapy (if used in lieu of a cutting operation), diagnostic and therapeutic endoscopic procedures, laser **surgery**, and injections classified as **surgery** under the CPT.

Surrogate mother: a woman who bears a child for another person, often for pay, either through artificial insemination or by carrying until birth another woman's surgically implanted fertilized egg.

Totally disabled: an individual is **totally disabled** when he or she is prevented because of **injury** or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

In any case where the **Plan Administrator** (or **Plan Supervisor** at the request of the **Plan Administrator**) is required to make a determination as to whether an individual is **totally disabled**, the **Plan Administrator** or **Plan Supervisor** shall have the right to require the individual to submit to an examination by a **physician** or medical clinic selected by the **Plan Administrator** or **Plan Supervisor**.

Variable-Hour Employee: means a **New Employee** if, based on the facts and circumstances at the **employee**'s **Start Date**, the Employer cannot determine whether the **employee** is reasonably expected to be employed on average at least 30 Hours of Service per week during the **Initial Measurement Period** because the **employee**'s hours are variable or otherwise uncertain. For purposes of determining whether an **employee** is a **Variable-Hour Employee**, the Employer may not take into account the likelihood that the **employee** may terminate employment before the end of the **Initial Measurement Period**. Although no single factor is determinative, the following factors may be relevant in determining whether a **New Employee** is a **Variable-Hour Employee**:

1. Whether the **employee** is replacing an **employee** who was a **Full-Time Employee** or a **Variable-Hour Employee**.
2. The extent to which the Hours of Service of **employee**s in the same or comparable positions have actually varied above and below an average of 30 hours of service per week during recent **Measurement Period**s.
3. Whether the job was advertised or otherwise communicated to the **new employee** or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, less than 30 hours of service per week, or might vary above and below an average of 30 hours of service per week.

COBRA CONTINUATION COVERAGE

What Is COBRA?

The right to **COBRA** continuation coverage was created by a federal law, the **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**. **COBRA** continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

When Would I Qualify For COBRA?

Continuation coverage is available if coverage would otherwise end due to:

- termination of your employment for reasons other than gross misconduct; or
- reduction in your work hours; or
- for your **dependent spouse** – divorce or legal separation from you; or
- for your **dependent spouse** or child(ren) – your death; or
- for your **dependent** child(ren), loss of eligibility as a covered **dependent** (e.g., because he or she reaches the maximum age provided by the plan); or
- for a **retiree**, if the former employer files for bankruptcy under Chapter 11.

What Must I Do To Notify My Employer Of An Event That Would Trigger COBRA Coverage?

If coverage would end because of divorce or legal separation, or because a child is no longer eligible to be a **dependent**, the **employee** or covered **dependent** MUST notify your Human Resources Department in writing. If your Human Resources Department is not notified within 60 days after the coverage would otherwise end, and the person is no longer eligible as a **dependent**, continuation coverage cannot be offered.

How Can I Elect COBRA?

When the employer receives notification of one of the above events, or when any other qualifying event occurs, you or the individual losing coverage will be notified of the right to continue coverage. If continuation is desired, the participant must elect to do so within 60 days of the date the notice was sent. Each covered member of the family may individually decide whether or not to continue coverage, but an election of coverage by the **employee** or **spouse** will be considered to be an election by all **covered individuals**, unless another **covered individual** rejects coverage.

What Is The Cost For COBRA Coverage?

Continuation is at the participant's expense. The monthly cost of this continued coverage will be included in the notice. Premiums are the same for all individuals who are in the same type of classification – adult single individuals have the same cost and family groups have the same cost.

When Must I Make Premium Payments?

For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. During the grace period, claims will be suspended until the premium is paid. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated.

How Long Can I Continue COBRA?

If coverage would otherwise end because employment ends or hours are reduced so you are no longer eligible for group benefits, continuation coverage may continue until the earliest of the following:

- 18 months from the date that the employment ended or the hours were reduced.
- The date on which a premium payment was due but not paid.
- The date the person continuing the coverage becomes covered by another employer's group health plan.
- The date, after continuation coverage has been elected, the person becomes entitled to **Medicare**.
- The date the employer terminates all of its group health plans.

If coverage would otherwise end for a covered **dependent** (**spouse** or child) because of divorce, legal separation, death or a child's loss of dependence status, continuation coverage may continue until the earliest of the following:

- 36 months from the date the covered **dependent's** coverage would have otherwise ended.
- The date on which the premium payment was due but not paid.
- The date the person continuing coverage becomes covered by another employer's group health plan.
- The date, after continuation coverage has been elected, the person continuing coverage becomes entitled to **Medicare**.
- The date the employer terminates all of its group health plans.

Can The Length Of COBRA Coverage Be Extended?

Second Qualifying Event

If continuation coverage was elected by a covered **dependent** because your employment ended or your hours were reduced and, if during the period of continued coverage, another event occurs which is itself an event which would permit continuation coverage to be offered, the maximum period of continued coverage for the covered **dependent** is extended for 18 months to a maximum of 36 months from the date of the initial event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Spouse and Dependents of **Medicare**-Eligible **Employees**

If continuation coverage was elected by your **spouse** or **dependent** child and you became entitled to **Medicare** while an **employee**, the maximum period of continuation coverage for **spouse** or child is the greater of 36 months from the date you became entitled to **Medicare** or 18 months from the date you lost coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals

If a **covered individual** is disabled, according to the Social Security Act, at the time he or she first becomes eligible for continuation or within 60 days of that date, the maximum period of continuation coverage is extended to 29 months. (Coverage will still end for any other reason listed above, such as failure to pay premiums when due, etc.) The **covered individual** must notify the employer within 60 days of the date he or she is determined to be disabled under the Social Security Act and within 30 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning 30 days after the **covered individual** is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage, and may be adjusted from time to time when group rates are adjusted.

Trade Act of 1974

Special **COBRA** rights apply to **employees** who have been terminated or experienced a reduction of hours and who qualify for a 'trade readjustment allowance' or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These **employees** are entitled to a second opportunity to elect **COBRA** coverage for themselves and certain family members (if they did not already elect **COBRA** coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact your Human Resources Department for additional information. You must contact your Human Resources Department promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special **COBRA** rights.

Special Provisions For Retirees

If your plan provides coverage for retirees, sometimes, filing a proceeding in bankruptcy under Title 1 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the **company** and that bankruptcy results in the loss of coverage of any retired **employee** covered under the plan, 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 the plan.

What Other Facts Should I Know Regarding My Rights Under COBRA?

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members who are or may become eligible for **COBRA**. You should also keep a copy of any notices you send the **Plan Administrator** for your records.

Who Should I Contact For Further Information And To Whom Should I Provide Notice Of COBRA Events?

If you need more information regarding continuation of coverage, please feel free to contact NGS CoreSource or contact the **Plan Administrator**. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

The **company** is responsible for administering Continuation Coverage. The **company** has contracted with NGS CoreSource to perform certain administrative functions on its behalf. These functions may include mailing of Continuation Coverage notices, collection of premium payments and reporting of paid participants to applicable vendors.

HIPAA PRIVACY RULES

HIPAA Privacy Rules refer to those provisions of the Health Insurance Portability and Accountability Act of 1996 that relate to the safe handling of Protected Health Information and the regulations issued thereunder in 45 CFR Parts 160 and 164.

Protected Health Information (PHI)

PHI includes information that the plan creates or receives that relates to the past, present, or future health or medical condition of an individual that could be used to identify the individual.

Use And Disclosure Of PHI

The plan can use or disclose PHI for purposes of Payment and Health Care Operations. "Payment" means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the plan, and other health care utilization review activities.

"Health Care Operations" refers to the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, **physician** reviews, compliance programs, audits, business planning, development, management, and administrative activities.

Business Associates Of The Plan

A Business Associate of the plan is a person or organization to whom the plan or another covered entity discloses PHI so that the Business Associate can carry out or assist with the performance of a function or activity of the plan. The activities might include claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, and repricing. Business Associates of the plan must contractually agree to abide by the HIPAA Privacy Rules and must require their subcontractors and agents to agree to abide by the HIPAA Privacy Rules.

Workforce Of The Plan

The plan has designated the Human Resources Director as the Privacy Official. The Privacy Official is the Privacy Fiduciary responsible for the plan's compliance with the HIPAA Privacy Rules. This includes ensuring that appropriate administrative procedures and safeguards are in place to protect PHI and ensuring that the Workforce of the plan and the Business Associates of the plan comply with the rules, are trained in the HIPAA Privacy Rules and the appropriate handling of PHI, and understand the sanctions for violations.

Certain **employees** of the **Plan Administrator** that serve on the Workforce of the plan are also considered Privacy Fiduciaries, including:

Human Resources Director	Finance Department Employees
Administrative Assistants	County Treasurer Employees
County Finance Director	MIS Department Employees

The plan has also designated NGS CoreSource as the Privacy Fiduciary for the following services: keeping PHI related to medical, dental, and vision claims; tracking the use and disclosure of PHI when it is necessary for accounting purposes; coordinating requests from an individual for Access, Amending, Accounting and Restriction of PHI.

Certain **employees** of the **Plan Administrator** whose duties include administrative and management functions on behalf of the plan are also considered part of the Workforce of the plan. Their access to PHI is limited to the minimum necessary information needed to perform their designated duties.

The plan has appointed the above **employees** of the **Plan Administrator** as **employees** of the plan's Workforce when they are performing functions related to Health Care Operations or Payment.

Individual Rights

Each individual covered under the plan ("the individual") is entitled to the protections set forth in this notice. For purposes of administration, "individual" shall mean:

1. In the case of the **employee**, former **employee**, surviving **spouse**, or head of any family continuing coverage under **COBRA** ("Primary **Covered Individual**"), the Primary **Covered Individual** may act as the individual for purposes of all Individual Rights and may receive PHI, such as claims correspondence and Explanation of Benefit forms on behalf of all covered family members, unless a restriction is otherwise requested and accepted by the plan.
2. In the case of any individual who has attained the age of 18, the individual may exercise their own Individual Rights as described in this notice.
3. In the case of a covered **dependent** child who has not attained the age of 18, the Primary **Covered Individual** or other parent may request and receive PHI on the **dependent** child or exercise Individual Rights on behalf of the **dependent** child.
4. In the case of a valid personal representative appointment on behalf of an individual, the personal representative shall be treated as the individual.
5. In the case of a person designated as an **alternate recipient** through a **Qualified Medical Child Support Order (QMCSO)**, that person has these rights to the PHI for the designated individual(s).

If an individual requests Access, Amending, Accounting, or Restriction of PHI for someone for whom they do not have the right, such as a **spouse** requesting an Accounting of PHI for the **employee** or the **employee** requesting an Accounting of PHI for a **dependent** over age 18, he/she must present a completed Personal Representative Affidavit or another legal document granting him/her authority.

An individual has the right to request Access to PHI, request an Amendment to PHI, request an Accounting of PHI disclosures, and request a Restriction in the handling of your PHI as set forth below.

Process To Request Access, Amending, Accounting Or Restriction Of PHI

Any request to exercise individual rights to Access, Amending, Accounting, or Restriction of PHI must be made in writing by completing the appropriate request form. The form must be provided to the appropriate Privacy Fiduciary.

Access To PHI

An individual has the right to access the following PHI from the plan within a Designated Record Set:

- Medical records
- Billing records
- Enrollment information
- Payment information
- Claim adjudication records

"Designated Record Set" means the plan's official records containing enrollment, medical/dental and billing records, and case management records that are used to make decisions about an individual's health care benefits. This would include:

1. Paper records stored in individual folders maintained by our claims payer.
2. Electronic records stored by individual family record within the claim payer's system, including Participant Enrollment, Coverage Detail, Individual and Family Accumulations and Totals, Paid Claims History, Patient Notes and the Image Retrieval System.
3. Working records only if used to make a decision about the individual's benefits under the plan and not available elsewhere in the Designated Record Set.
4. Documentation of phone inquiries or information obtained via telephone call only if used to make a decision about the individual's benefits under the plan and maintained via telephone recording.

The following types of information are not included in the Designated Record Set:

1. Health information that was not used to make decisions about individuals or their benefits.
2. Psychotherapy notes (as defined in the HIPAA Rule).
3. Copies of documents wherein the source documentation is maintained in an 'official' record maintained by the plan or plan's Business Associate. Copies of PHI maintained in more than one location must be protected but only the source document is included in a Designated Record Set.
4. Information compiled in reasonable anticipation of, or for use in civil, criminal, or administrative action or proceeding (e.g., Incident reports - used to identify problems and implement corrective action).

A plan representative will respond to the request to access PHI within 30 days from the date the request is received. If the PHI is not on site, the plan representative may obtain the information and furnish it within 60 days from the date of the request. If additional time is needed, the plan representative will notify the requesting individual of a 30-day extension and reasons for the delay and advise him/her of the date the request should be completed.

If the plan representative is aware that the PHI is held by another entity, the plan representative will advise the name and address of the entity and how the individual may contact them for the PHI. There may be a reasonable charge for obtaining, copying, and mailing the requested information. The PHI will be provided in the format requested, if possible. If the individual agrees in advance, a summary form of the record will be provided.

Denial Of Access

If access of PHI is denied, the plan representative will furnish a written denial. The denial will provide the reason as well as the individual's rights, if any, to have the denial reviewed. The denial will contain the name and address of the person to whom the individual can send their complaint and request for review.

Denials made for the following reasons will not be given subsequent review:

- An inmate requests access and that access would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or others.
- The individual consented to access rights during the course of research involving treatment until the completion of the research.
- The HIPAA Privacy Rules permit denial.
- The PHI was received from a source with a promise of confidentiality and access is likely to breach that confidentiality.
- The PHI is not part of the Designated Record Set maintained by the plan.
- Where the individual who is the subject of the PHI is an individual who has attained the age of 18, or the personal representative of an individual under the age of 18 and has filed, and the plan has accepted, a restriction of access that would be violated by providing the requested access.

Denials for the following reasons may be reviewed, upon request, by a licensed **health care professional** not involved in the decision to deny access:

- A licensed **health care professional** reasonably believes that access will endanger the life or safety of the individual or others.
- The PHI refers to others and the **health care professional** determines that access is likely to substantially harm the other person.

Amending PHI

An individual has the right to request that PHI in a Designated Record Set be amended.

Once an amendment to PHI is requested, the plan representative will make a decision regarding the request within 60 days from receipt. If additional time is needed, the plan representative will notify the individual requesting the amendment and take an additional 30 days to make a decision.

If the plan representative is aware that the PHI is held by another entity, the plan representative will advise the requesting individual the name and address of the entity and how they may contact them to amend the PHI.

If the plan representative grants the amending of PHI, a copy of the request and decision will be placed in any Designated Record Set maintained by the plan with information relating to the individual.

If the plan representative has furnished information concerning the amended information to another entity, they will contact the individual to obtain consent to advise that entity of the amended information and will make reasonable efforts to inform that entity of the amendment.

Denial Of Request To Amend PHI

If access of PHI is denied, the plan representative will furnish a written denial. The denial will provide the reasons as well as the individual's rights to have the denial reviewed. The denial will contain the name and address of the person to whom the individual can send their complaint and request for review.

Denial to amend PHI may be made for the following reasons:

- The plan did not create the PHI.
- The PHI is not part of the Designated Record Set maintained by the plan.
- The PHI would not be available for access according to the HIPAA Privacy Rules.
- The PHI is accurate and complete.

If an individual disagrees with the denial, they may submit a statement of disagreement. The plan representative will review that statement. If the plan representative agrees, the PHI will be amended. If the plan representative does not agree, they will notify the individual requesting the amendment.

If a disagreement is filed, it and all subsequent responses will be included or summarized in future disclosure of the individual's PHI.

If an individual does not submit a statement disagreeing with the denial, they can request that the request for amendment and the denial be included in any future disclosures of PHI.

Amending PHI When Notified By Another Entity

If another entity notifies the plan that they have amended PHI previously given, the PHI in the Designated Record Set will be amended.

Accounting For The Use Of PHI

An individual can request an accounting of any disclosures of PHI made by the plan for up to six years prior to the date of the request, except disclosures made:

- To carry out treatment, payment, and health care operations or made pursuant to an authorization.
- Upon request of and made to the individual.
- For facility directory, or persons involved in the individual's care.
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials.
- Made prior to the compliance date of the HIPAA Privacy Rules.

The plan representative will furnish the following information:

- The date of the disclosure.
- The name of any entity or person who received PHI and their address, if known.
- A brief description of the PHI disclosed.
- A brief statement on the basis of the disclosure.

A response to a request will be given within 60 days from the receipt of the request. The plan representative will notify the individual if more time is needed and the reason for the delay, as well as the date by which the accounting will be provided. The plan representative will not take more than an additional 30 days to furnish the accounting.

Requesting Restriction Of Use Of PHI

An individual may request the plan restrict the use or disclosure of PHI.

The plan will accept a reasonable request to release information to an alternate address for each family member. Such a request will be honored for all information released until the plan is notified in writing that the alternate address should not be used.

The plan will accept an individual's reasonable request to release information to an alternate address in the event that access to the PHI will endanger the life and/or safety of the individual or others. In the event of a minor child being the subject of abuse or endangerment, a letter from a licensed **health care professional** shall be treated as the individual's request for confidential communications. Such reasonable request will be honored for all information released until the plan is notified in writing that the alternate address should not be used.

Notification Of A Breach

An individual has the right to be notified in the event that the plan (or one of its Business Associates) discovers a breach of their unsecured PHI. Notice of such a breach will be made in accordance with federal guidelines.

Applicability Of State Laws

The administration of the Medical Plan involves resources, individuals, services and activities in several States. Therefore, the Medical Plan observes the health information privacy laws of the various States to the extent that the State law in question meets either of the following HIPAA requirements:

a. It is possible for the Medical Plan to comply with both HIPAA and that State law; or

b. While it is impossible for the Medical Plan to comply with both HIPAA and that State law, the State law still applies because one (or more) of the following applies:

   i. The State law relates to the privacy of Individually Identifiable Health Information, and the State law requirements are "more stringent" than the requirements under HIPAA. For this purpose, "more stringent" generally means that the State privacy law provides for any of the following when compared to HIPAA:
      - Greater restriction in use or disclosure;
      - Greater access or amendment by an individual to Individually Identifiable Health Information;
      - Greater amount of information about a use, disclosure, right and remedies to be provided to an individual;
      - Narrower scope or duration of an express legal permission for use or disclosure of Individually Identifiable Health Information;
      - Longer record retention or more detailed reporting; or
      - Greater privacy protection for the individual with respect to any other matter.

   ii. The State law provides for health reporting for certain public health purposes.

   iii. The State law requires the Medical Plan to report or provide access to information for purposes of certain audits, licensure and certification.

   iv. The secretary determines that the State law is necessary to (A) prevent certain fraud and abuse, (B) to ensure appropriate State regulation of insurance and Health Plans to the extent expressly authorized by statute or regulation, (C) for state reporting on health care delivery or costs, or (D) to service compelling public, health, safety or welfare interests.

Separation Of Plan And Plan Administrator

The **Plan Administrator** has provided a certification that requires assurance that the **Plan Administrator** will appropriately safeguard and limit the use and disclosure of PHI that the **Plan Administrator** may receive from the plan to perform plan Administration Functions. Specifically, **Plan Administrator** has agreed:

- not to use or further disclose PHI other than as permitted or required by the **Plan Document** or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan agree to the same restrictions and conditions that apply to the Administrator with respect to such information;
- not to use or disclose PHI for employment related actions and decisions or in connection with any other benefit or **employee** benefit plan;
- to report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;

- to make available information in accordance with the HIPAA Rules regarding individual access to PHI;
- to make available PHI for amendment in accordance with the HIPAA Rules;
- to make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;
- to make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
- to, if feasible, return or destroy all PHI received from the plan that **Plan Administrator** still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure the separation of the plan and the Administrator as set forth under "Workforce of the Plan."

Permitted **employees** may also use the PHI for plan Administrative Functions that the **Plan Administrator** performs for the plan such as:

- Summary Health Information for the purpose of obtaining premium bids, including bids in connection with the placement of stop loss coverage;
- Summary Health Information for use in making decisions to modify, amend, or terminate the plan.

"Plan Administrative Functions" mean administrative functions performed on behalf of the plan and excludes functions performed by the **Plan Administrator** in connection with any other benefit or benefit plan of the **Plan Administrator**.

Any controversy or claim arising out of or relating to a violation of any of the separation and/or disclosure provisions agreed to in the certification and described in this notice may be reported to:

What Other Types Of Activities Involve The Collection Or Use And Disclosure Of PHI?

1. Activities required or permitted by law. The following examples provide information on uses and disclosures required or permitted by law:

   - The plan may share PHI with government or law enforcement agencies when required to do so. The plan may also share PHI when required to in a court or other legal proceeding.
   - The plan may share PHI to obey Workers' Compensation laws.
   - The plan may share PHI with the individual if the individual requests access to PHI as described previously in the Individual Rights section of this notice.

2. Activities performed with authorization

   In other situations, the plan will ask for the individual's written authorization before using or disclosing PHI.

An individual may decide later that they no longer want to agree to a certain use of PHI for which the plan received authorization. If so, the individual may write to the plan and revoke their authorization. If the plan had authorization to use PHI, the revocation will not apply to those past situations.

The Plan's Legal Obligations

This plan is legally required to maintain the privacy of PHI as set forth in this notice. The plan is required to send a Notice of Privacy Practices to the Primary **Covered Individual** and abide by its contents. If an individual feels that their rights have been violated, they may file a complaint with the plan's Privacy Official at the address below. An individual may also file a complaint with the Secretary of the Department of Health and Human Services.

1. A complaint must be filed in writing, either on paper or electronically.
2. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements.
3. A complaint must be filed within 180 days of when the complainant knew or should have known of the act or omission.

Privacy Policy Changes

The plan may change the privacy policies from time to time to comply with the understanding of applicable laws and to provide the best service possible under the plan. Any change in policy will be made available to **covered individuals**.

For information or questions about our policies write the Privacy Official at the following address:

Human Resources Director
Employee Medical Benefit Plan
200 E. Virginia Avenue
Gunnison, CO 81230
(970) 641-7623

The Contact Office If an Individual wishes to exercise their rights to request access or amend PHI, or receive an accounting of disclosures or a restriction on use or disclosure of PHI, the Individual may contact the plan's Privacy Official or the Contact Office listed above or the organization listed below:

Privacy Office
NGS CoreSource
19800 Hall Road
Clinton Twp., MI 48038
(800) 521-1555

If you wish to file a complaint an Individual may call or write the County Privacy Official at the following address:

County Privacy Official
Matthew Birnie
200 E. Virginia Avenue
Gunnison, CO 81230
(970) 641-0248, option 2

HELP FIGHT FRAUD

Combating fraud and abuse takes a cooperative effort from each of us. One way for you to help is by reviewing your Explanation of Benefits (EOB) to be sure that the services billed to us were reported properly. If you should see a service and/or supply billed to us that you did not receive, please report that immediately in writing. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- The name and address of the provider,
- The name of the beneficiary who was listed as receiving the service or item,
- The claim number,
- The date of the service in question,
- The service or item that you do not believe was provided,
- The reason why you believe the claim should not have been paid, and
- Any additional information or facts showing that the claim should not have been paid.

Detection Tips

You should be suspicious of practices that involve:

- Providers who routinely do not collect your cost share (co-payment).
- Billing by your provider for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

Prevention Tips

- Always protect your NGS CoreSource identification card. Know to whom you are giving your member ID number. Do not provide your member number to someone over the phone if they call you.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but knows how to bill for the item or service to get it paid.

Who Do I Contact If I Suspect Fraud, Waste Or Abuse?

Mail: NGS CoreSource
P.O. Box 2310
Mt. Clemens, MI 48046

Phone: 1-800-521-1555

HOW TO FILE MEDICAL CLAIMS

A General Overview

A claim is defined as any request for a plan benefit made by a **claimant** that complies with the plan's reasonable procedure for making benefit claims.

There are different types of claims. Reasonable claim filing procedures, which are different for each type of claim, are described below. Each type of claim has a specific timetable for approval, payment, request for further information, denial of the claim and for review of any **adverse benefit determination**.

The times listed below for response and appeals are maximum times only. A period of time begins at the time the claim is received, as explained in the claim filing procedures for each type of claim. Decisions will be made within a reasonable period of time appropriate to the circumstances. Throughout this section, "days" means calendar days.

What Should You Know About Pre-Service Claims?

Whenever the plan requires advance approval of a service or treatment, the purpose of a **pre-service claim** is to provide the **claimant** with a determination of whether or not the approval process will prevent payment of the claim and to give you the opportunity to appeal any **adverse benefit determination** made during the pre-approval process. However, the claim determination made on a **pre-service claim** review does not guarantee payment of any **post-service claim**.

This plan does not condition benefit payment, whether an urgent care claim or a non-urgent care claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, NGS CoreSource, P.O. Box 2310, Mt. Clemens, MI 48046, or by calling (800) 521-1555.

Plan Procedures For Filing A Pre-Service Claim

A **claimant** may file a **pre-service claim** by telephone, mail or electronic media. The plan may have specific requirements associated with notification of **pre-service claims**. See the sections titled "Does this Plan have a Pre-Certification Provision?" and "What if I Need a Prescription Medication?" for further information.

The following information should be provided to the **Claims Administrator** for **pre-service claims**.

- The **employee's** name, name of the employer and four-digit division code; this information is embossed on your NGS CoreSource identification card.
- The **employee's** unique identification number.
- The name of the patient and relationship to the **employee**.
- The proposed date of service.
- The **diagnosis** and type of service to be provided.

The **Claims Administrator** must reply to the claim request within a certain time period. The **claimant** must also respond to any request from the **Claims Administrator** within certain time periods. Those time periods are described below.

Urgent Care Pre-Service Claims

If an urgent care **pre-service claim** is filed following the proper claims filing procedures, and no additional information is needed, the **Claims Administrator** will notify the **claimant** of a decision within 72 hours.

If additional information is needed the **Claims Administrator** will notify the **claimant** within 24 hours. The **claimant** will have up to 48 hours from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 48 hours after the request for information.

When proper claims filing procedures are not followed, the **Claims Administrator** must notify the **claimant**, orally or in writing, within 72 hours of receipt of the claim. The **claimant** must respond to that notification within 72 hours. If the **claimant** does not properly file the claim within 72 hours, the claim will be denied. If the **claimant** properly files the claim within 72 hours, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours of receipt of the properly filed claim.

If an **adverse benefit determination** is given, the **claimant** may appeal the decision. Refer to the section titled "**Adverse Benefit Determination**s and Appeals" for further information.

Please note that if you or your dependent need medical care that would be considered urgent care or **emergency services**, then there is no requirement that the plan be contacted for prior approval.

Non-Urgent Care Pre-Service Claims

If a non-urgent **pre-service claim** is filed following the proper claims filing procedures and no additional information is needed, the **Claims Administrator** will notify the **claimant** of a decision within 15 days.

If additional information is needed, or there are matters that prevent a decision and they are beyond the control of the plan, the **Claims Administrator** will notify the **claimant** within 15 days. The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of your response. If the **claimant** does not respond to the request for information, the claim will be denied within 60 days after the request for information. Should the required information be submitted subsequently, the claim will be considered a new request and will be reviewed in accordance with the above guidelines, if filed within the claim filing timeframe (refer to the section titled "What is Not Covered?").

When proper claims filing procedures are not followed, the **Claims Administrator** must notify the **claimant**, orally or in writing, within 5 days of receipt of the claim. The **claimant** must respond to that notification within 15 days. If the **claimant** does not properly file the claim within these 15 days, the claim will be denied.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. Please see the section titled "**Adverse Benefit Determination**s and Appeals" for further information.

What Should You Know About Post-Service Claims?

Plan Procedures For Filing A Post-Service Claim

The **claimant** may file a **post-service claim** by mail or electronic media directly with the **Claims Administrator**. The plan does not require the filing of a claim form. When a provider files a claim, they will be considered the **authorized representative** of the patient.

For medical **post-service claims**, your **Claims Administrator** is NGS CoreSource, P.O. Box 2310, Mt. Clemens, MI 48046, 1-800-521-1555.

The **Claims Administrator** for pharmacy **post-service claims** is Caremark, 750 W. John Carpenter Freeway, Suite 600, Irving, TX 75039, (866) 818-6911.

Original bills and/or receipts with the complete claims information listed below should be sent to NGS CoreSource. In the case of a bill from a **network provider** where the network requires claims be submitted through them, the bill will not be considered a claim until it is received by the network. In addition to bills filed by hard copy, NGS CoreSource will consider claims filed electronically as original claims.

Required Information

When submitting a medical claim, the following information must be presented:

- The **employee's** name, name of the employer and four-digit division code; this information is embossed on your NGS CoreSource identification card.
- The **employee's** unique identification number.
- The name of the patient and relationship to the **employee**.
- The date of service.
- The provider's name and degree.
- The medical condition for which treatment was provided.
- The charge for each specific service.

This plan intends, through NGS CoreSource, to promptly acknowledge and make a claims determination on claims submitted. In order to do this, the plan needs your cooperation. In most cases when a bill is sent to NGS CoreSource directly by the provider, the claims information listed above will be on the bill. If you send a bill or receipt to NGS CoreSource, you should be sure the above claim information is given.

Prescription drugs purchased in a participating pharmacy are covered by the **prescription drug** benefit administered by CVS Caremark. Prescriptions filled at a participating pharmacy will be covered as described in the section titled "What if I Need a Prescription Medication?" If you or your **dependent** purchases a drug at a non-participating pharmacy, you or your **dependent** must pay for the prescription in full.

Providing Additional Information

Additional information provided at the time of the claim will help in making a determination. For example, if the bill is for your covered **dependent** who has other medical coverage, send a copy of the other coverage's proof of payment or denial.

If the bill is for services rendered due to an accidental bodily **injury**, please provide the following details:

- How the accident happened?
- When the accident happened?
- The name and address of anyone who was responsible for the **injury**.

Time Periods For The Plan And You

The **Claims Administrator** must reply to a claim request within a certain time period. The **claimant** must also respond to the request for additional information from the **Claims Administrator** within certain time periods.

When a **post-service claim** is filed, and all information needed to make a claim determination is present, the **Claims Administrator** must notify the **claimant** of a claims decision within 30 days from the date the claim is received.

If a **post-service claim** is filed and additional information is needed, the **Claims Administrator** must notify the **claimant** within 30 days.

The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 60 days after the request for information. Should the required information be submitted subsequently, the claim will be considered a new request and will be reviewed in accordance with the above guidelines, if filed within the claim filing timeframe. See the section titled "What is Not Covered?" for additional information regarding the claims filing timeframe.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. Please see the section titled "**Adverse Benefit Determination**s and Appeals" for further information.

ADVERSE BENEFIT DETERMINATIONS AND APPEALS

What If My Claim Is Denied?

Except with urgent care claims, when the notification may be given orally followed by written or electronic notification within three days of the oral notification, the **Plan Administrator** shall provide written or electronic notification of any **adverse benefit determination**. The notice will state, in a manner calculated to be understood by the **claimant**:

1. The specific reason or reasons for the **adverse benefit determination**.
2. Reference to the specific plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the **claimant** to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the plan's review procedures and the time limits applicable to such procedures. This will include a statement of the **claimant's** right to bring a civil action under section 502 of ERISA following an **adverse benefit determination** or review.
5. A statement that the **claimant** is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the **adverse benefit determination** was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion which was relied on will be provided free of charge to the **claimant** upon request.
7. If the **adverse benefit determination** is based on medical necessity or **experimental** or **investigational** treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the **claimant's** medical circumstances, will be provided free of charge to the **claimant** upon request.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with **Plan Documents** and plan provisions have been applied consistently with respect to all **claimants**; or
4. Constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.

How Do I File An Appeal?

If a **claimant** receives an **adverse benefit determination** for an urgent **pre-service claim**, the **claimant** may appeal that decision in writing, via mail, facsimile, or electronically. If a **claimant** receives an **adverse benefit determination** for a non-urgent **pre-service claim** or a **post-service claim**, the **claimant** may appeal the decision within 180 days of date of the **adverse benefit determination**. The appeal and all supporting documentation should be submitted to the **Plan Administrator**.

The following describes the review process and rights of the **covered individual**:

1. The **covered individual** has the right to submit documents, information and comments and to present evidence and testimony.
2. The **covered individual** has the right to access, free of charge, relevant information to the claim for benefits. A document, record, or other information shall be considered relevant to a claim if it:
    a. Was relied upon in making the benefit determination;
    b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
    c. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with **Plan Documents** and plan provisions have been applied consistently with respect to all **claimants**; or
    d. Constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.
3. Before a final determination on appeal is rendered, the **covered individual** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the **covered individual** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the **covered individual**, even if it was not considered in the initial benefit determination.
5. The review will not afford deference to the original denial.
6. The review will be conducted by an **employee** of the **Plan Administrator** who is neither:
    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
    a. The **Plan Administrator** will consult with a **health care professional** who has appropriate training and experience in the field involving the medical judgment; and
    b. The **health care professional** utilized by the **Plan Administrator** will be neither:
        i. An individual who was consulted in connection with the original denial of the claim, nor
        ii. A subordinate of any other **health care professional** who was consulted in connection with the original denial.

8. If requested, the **Plan Administrator/Claims Administrator** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

Notice Of Benefit Determination On Appeal

The **Plan Administrator** shall provide the **claimant** with a written notice of the appeal decision within applicable time period. If a **claimant** receives an **adverse benefit determination** for an urgent **pre-service claim**, the **Plan Administrator** will provide a decision regarding the appeal within 72 hours. If a **claimant** receives an **adverse benefit determination** for a non-urgent **pre-service claim**, the **Plan Administrator** will review the appeal and respond within 30 days. If a **claimant** receives an **adverse benefit determination** for a **post-service claim**, the **Plan Administrator** will review the appeal and respond within 60 days.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the plan. This timing is without regard to whether all the necessary information accompanies the filing.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific plan provisions on which the denial is based.
3. A statement that the **covered individual** has the right to access, free of charge, relevant information to the claim for benefits. A document, record, or other information shall be considered relevant to a claim if it:
    a. Was relied upon in making the benefit determination;
    b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
    c. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with **Plan Documents** and plan provisions have been applied consistently with respect to all **claimants**; or
    d. Constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.
4. A statement of the **covered individual's** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the **covered individual's** appeal is denied, the **covered individual** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the **Plan Administrator** will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the plan to the **claimant's** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

External Appeals

A **claimant** may request a review of a denied claim by making written request to the **Plan Administrator** within four months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. The plan may charge a filing fee to the **covered individual** requesting an external review, subject to applicable laws and regulations.

Right To External Appeal

Within five business days of receipt of the request, the **Plan Supervisor** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The **covered individual** incurring the claim is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
2. The final internal denial does not relate to the **covered individual's** failure to meet plan eligibility requirements as stated in the section titled "Participating in the Plan";
3. The **claimant** has exhausted the plan's appeal process, to the extent required by law; and
4. The **claimant** has provided all of the information and forms required to complete an external review.

Notice Of Right To External Appeal

The **Plan Administrator** shall provide the **claimant** with a written notice of the decision as to whether the claim is eligible for external review within one business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the **claimant** to perfect the external review request by the later of the following:
    a. The four month filing period; or
    b. Within the 48 hour time period following the **claimant's** receipt of notification.

Independent Review Organization

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the **claimant** in writing of the request's eligibility and acceptance for external review.

Notice Of External Review Determination

The assigned IRO shall provide the **Plan Administrator** and the **claimant** with a written notice of the final external review decision within 45 days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the **claimant**, the **Plan Administrator** and **Plan Supervisor**, except to the extent that other remedies may be available under State or Federal law.

Expedited External Review

The **Plan Administrator** shall provide the **claimant** the right to request an expedited external review upon the **claimant's** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the **covered individual** or the **covered individual's** ability to regain maximum function and the **covered individual** has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the **covered individual** or the **covered individual's** ability to regain maximum function or if the final determination involves any of the following:
    a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the **covered individual** received **emergency services**, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the section, “Right to External Appeal.”
2. Send notice of the plan’s decision, as described in the section, “Notice of Right to External Appeal.”

Upon determination that a request is eligible for external review, the plan will do all of the following:

1. Assign an IRO as described in the section, “Independent Review Organization.”
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the **covered individual’s** medical condition or circumstances require, but in no event more than 72 hours after receipt of the expedited external review request. The notice shall follow the requirements in section, “Notice of External Review Determination.” If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the **Plan Administrator** and the **claimant** written confirmation of its decision within 48 hours after the date of providing that notice.

Is The Decision On Review Final?

The decision by the **Plan Administrator** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the plan must be exhausted before any legal action is brought.** No action at law or in equity shall be brought to recover on the benefits from the plan after the expiration of two years from the date the expense was incurred or one year from the date the completed claim was filed, which ever occurred first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this plan in accordance with its provisions have been made under any other plans, the plan shall have the right, exercisable alone and its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this coordination provision. Any amount so paid shall be deemed to be benefits paid under this plan and to the extent of such payments; the plan shall be fully discharged from liability.

Plan payments will be made to the provider whenever there is no evidence showing that the provider has been paid. If the provider has been paid and the **employee** authorizes payment to another individual, the plan will pay that individual upon receipt of the **employee's** signed authorization.

If an **employee** dies, the plan will determine payment of claims as follows:

- First, to any providers who have not received payment that would be due under the plan;
- Second, the **employee's spouse**;
- Third, the **employee's** estate.

PHYSICAL EXAMINATION

This plan, at its own expense, will have the right and opportunity to have any individual whose medical or **dental** treatment is the basis of a claim under this plan, examined by a **physician** designated by this plan when and as often as it may be reasonably required during the review of a claim under this plan.

FRAUD OR INTENTIONAL MISREPRESENTATION

Any fraud or intentional misrepresentation, as defined under the provisions of the **ACA**, of a material fact on the part of the **covered individual**, an individual seeking coverage on behalf of the **covered individual** in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the plan null and void. The plan shall be entitled to recover its damages, including legal fees, from the **covered individual**, or from any other person responsible for misleading the plan, and from the person for whom the benefits were provided.

SUBROGATION/REIMBURSEMENT

The plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a **covered individual** in a time of need, however, the plan may pay covered expenses that may be or may become the responsibility of another person, provided that the plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the plan, as well as by applying for payment of covered expenses, a **covered individual** is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the plan:

1. Assignment of Rights (Subrogation). The **covered individual** automatically assigns to the plan any rights the **covered individual** may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts, and health savings accounts), but limited to the amount of Reimbursable Payments made by the plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a **covered individual** or paid to another for the benefit of the **covered individual**. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the **covered individual** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or **dental** charges, attorney fees, or other costs and expenses. This assignment also allows the plan to pursue any claim that the **covered individual** may have, whether or not the **covered individual** chooses to pursue that claim. By this assignment, the plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The plan shall have an equitable lien against any rights the **covered individual** may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. The equitable lien also attaches to any right to payment from Workers' Compensation, whether by judgment or settlement, where the plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the **covered individual**, the **covered individual's** attorney, and/or a trust) as a result of an exercise of the **covered individual's** rights of recovery (sometimes referred to as "proceeds"). The plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **Plan Administrator**, the plan may reduce any future covered expenses otherwise available to the **covered individual** under the plan by an amount up to the total amount of Reimbursable Payments made by the plan that is subject to the equitable lien.

This and any other provisions of the plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002); and Sereboff v. Mid Atlantic Medical Services, Inc. (MAMSI), 126 S.Ct. 1869, 547 US 356 (2006). The provisions of the plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Plan's Reimbursement Activities. The **covered individual** has an obligation to assist the plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the **covered individual**, and to provide the plan with any information concerning the **covered individual's** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the **covered individual**. The **covered individual** is required to (a) cooperate fully in the plan's (or any plan fiduciary's) enforcement of the terms of the plan, including the exercise of the plan's right to subrogation and reimbursement, whether against the **covered individual** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the plan as a co-payee for the amount of the Reimbursable Payments and notifying the plan), (c) sign any document deemed by the **Plan Administrator** to be relevant to protecting the plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **Plan Administrator** to enforce the plan's rights.

4. Overpayments. This plan will have the right to recover any payments that were made to, or on behalf of, a **covered individual** and which causes an overpayment to be made.

Failure by **covered individuals** to follow the above terms and conditions may result, at the discretion of the **Plan Administrator**, in a reduction from future benefit payments available to the covered person under the plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the plan.

GENERAL PLAN INFORMATION

Plan Name

The name of the plan is Gunnison County, Colorado Employee Medical Benefit Plan as Amended and Restated Effective January 1, 2016.

Type Of Plan

This plan is a welfare benefits plan providing medical benefits. This plan is not subject to ERISA.

Plan Number

The plan number is 501.

Plan Administrator And Named Fiduciary

The **Plan Administrator**, named fiduciary and agent for service of legal process is Gunnison County, Colorado, 200 E. Virginia Avenue, Gunnison, CO 81230, (970) 641-7623.

Employer Identification Number

The employer identification number for Gunnison County, Colorado is 84-6000770.

Cost Of The Plan

Gunnison County, Colorado shares in the cost of providing benefits for you and your eligible **dependents**. Information regarding the specific cost for coverage can be obtained from your Human Resources Department.

Plan Effective Date

The original plan effective date is January 1, 2000. The plan is amended and restated effective January 1, 2016.

Plan Distribution Date

Benefits described in this **SPD** will only apply to claims incurred on or after the plan effective date or the date on which the plan is distributed whichever is later.

Plan Year

The fiscal year of this plan commences on the first day of January and ends on the last day of the following December.

Plan Supervisor

The **Plan Supervisor** is NGS CoreSource, 19800 Hall Road, Clinton Twp., MI 48038, 1-800-521-1555.

The Plan Is Not A Contract Of Employment

This plan does not constitute or provide a promise or guarantee of employment or continued employment, to any **employee** of the **Plan Administrator** or of any participating employer. Nor do these documents change any such employment relationship to be other than employment "at will."

YOUR RIGHTS UNDER THIS PLAN

What Are My Rights Under This Plan?

As a participant in the plan, you are entitled to certain rights and protections. The plan provides that all plan participants shall be entitled to the following rights.

The Right To Receive Information About The Plan

You can examine, without charge, all documents governing the plan, including insurance contracts and collective bargaining agreements. The documents are available for examination at the **Plan Administrator's** office and at other specified locations, such as worksites and union halls.

You can also obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, as well as copies of the **SPD**. The **Plan Administrator** may charge a reasonable fee for the copies.

The Right To Continue Group Health Plan Coverage

You can continue health care coverage for you or your **dependents** if there is a loss of coverage under the plan as a result of a qualifying event. You or your **dependents** may have to pay for such coverage. It is important that you review this **SPD** and any other documents governing the plan on the rules governing your **COBRA** continuation coverage rights.

The Right To Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the **Claims Administrator** review and reconsider your claim.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may bring a civil action. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may file suit in court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

NOTE: No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Who Are The Fiduciaries Of The Plan?

Gunnison County, Colorado is the **Plan Administrator** and named fiduciary within the meaning of Section 402(a) (1) of ERISA for everything not delegated to another fiduciary in this document. Gunnison County, Colorado shall exercise all discretionary authority and control with respect to management of the plan that is not specifically granted to another fiduciary.

Gunnison County, Colorado may delegate certain fiduciary responsibilities under the plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility should be made by written instrument executed by Gunnison County, Colorado. A copy of the written instrument delegating the responsibility will be kept with the records of the plan.

NGS CoreSource has, by written instrument, been designated as the Fiduciary for Final Claims Determination for medical **post-service claims** submitted to the plan. By making this designation, it is the Plan Sponsor's intention that NGS CoreSource makes final claim determinations and has final discretion in construing the terms of the plan with respect to final claim determinations. NGS CoreSource shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

What Are The Fiduciaries' Responsibilities?

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Each fiduciary under the plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

What If The Plan Is Modified, Amended Or Terminated?

Gunnison County, Colorado, by a duly **authorized representative**, may modify, amend, or terminate the plan at any time at its sole discretion.

Any such modification, amendments, or terminations that affect plan participants or beneficiaries of the plan will be communicated to them. If the plan is terminated, benefits will only be paid for claims incurred before the date of termination up to the time funds are no longer available.

Who Is Responsible For The Administration Of The Plan?

Gunnison County, Colorado is the **Plan Administrator**. As **Plan Administrator**, Gunnison County, Colorado is required to supply you with this booklet and other information, and to file various reports and documents with government agencies. In its role of administering the plan, the **Plan Administrator** also may make rulings, interpret the plan, prescribe procedures, gather needed information, receive and review financial information of the plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering the plan.

The **Plan Administrator** shall have any and all powers of authority, except as otherwise delegated in this document, which shall be proper to enable him/her to carry out his/her duties under the plan. Examples of such powers and authority are as follows: (i) the powers and authority contemplated by the **Employee** Retirement Income Security Act of 1974 ("ERISA") with respect to **employee** welfare plans, and (ii) the powers of authority to make regulations with respect to the plan that are consistent with the plan or ERISA, and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The **Plan Administrator** will determine eligibility for benefits under the plan. The **Plan Administrator** has delegated fiduciary responsibility for medical **post-service claim** decisions to: NGS CoreSource. The plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not preempted by Federal law, the laws of the state of Colorado.

In exercising its authority under this plan, the **Plan Administrator** or any fiduciary to whom authority has been granted under this plan, shall have full and absolute discretion, and any decisions of the **Plan Administrator** or other fiduciary may not be overturned in a subsequent judicial or administrative proceeding unless found to be arbitrary and capricious.

How Is The Plan Funded?

The plan is funded through the general assets of Gunnison County, Colorado, and contributions as required. In the event of plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the plan should be terminated, claims incurred prior to the date of such termination would be paid until the time funds are no longer available. Claims incurred after the date of such termination would not be paid.

Is This Plan Considered Health Insurance?

Under Michigan law, the **Plan Supervisor** is required to disclose the following information.

Gunnison County, Colorado Employee Medical Benefit Plan is a self-funded plan. You and your covered **dependents** are not insured. In the event this plan does not ultimately pay medical expenses that are eligible for payment under this plan for any reason, you or your covered **dependents** may be liable for those expenses.

The **Plan Supervisor**, NGS CoreSource, merely processes claims and does not ensure that any medical expenses of individuals covered by this plan will be paid.

When you or your covered **dependent** file complete and proper claims for benefits, those claims will be promptly processed. In the event of a delay in processing, then you or your covered **dependent** shall have no greater right or interest or other remedy against the **Plan Supervisor**, NGS CoreSource, than as otherwise afforded by law.

EXECUTION

Gunnison County, Colorado Employee Medical Benefit Plan as Amended and Restated Effective January 1, 2016 is hereby approved and adopted this _____day of _____, 2016.

GUNNISON COUNTY, COLORADO

BY: _____

TITLE: _____