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**DAVENPORT COMMUNITY SCHOOL DISTRICT #1611  
EMPLOYEE HEALTH BENEFIT PLAN**

*Summary Plan Description*  
July 2016

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## ***INTRODUCTION***

The Davenport Community School District #1611 Employee Health Benefit Plan is a self-funded health benefit plan established to provide medical benefits for Employees of the Davenport Community School District #1611. ("Employer"). This Plan represents the efforts of the Employer to provide Employees and their dependents with healthcare benefits.

This booklet provides you with a summary of all major benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the "Definitions" Section. It will be helpful to refer to these definitions as you review your benefits.

If you have questions about the Plan, you may contact the Plan's Third Party Administrator for assistance between 8:00 a.m. and 4:30 p.m., Monday through Friday, using the telephone number listed on the General Information page.

While the Third Party Administrator can help with general information and explanations on how the Plan works it does not have authority to promise or guarantee Plan benefits. All benefit claims are processed under the Plan terms contained in this document. In the event your claim for benefits under the Plan is denied in part or in whole, you have a right to appeal the denial. The Plan Administrator acts as the named Fiduciary for the Plan, and retains the sole discretionary authority to interpret and apply Plan terms, to resolve any inconsistencies or conflicts in this document, and to determine and correct any errors or omissions.

## ***GENERAL INFORMATION***

The following information, together with the information contained in this booklet, form the Master Plan Document and Summary Plan Description of the Plan.

**1. Name of Plan:**

*Davenport Community School District #1611 Health Benefit Plan*

**2. Name and Address of Plan Sponsor and Plan Administrator:**

*Davenport Community School District #1611  
1702 N. Main St.  
Davenport, Iowa 52803  
(563) 445-5000*

**3. Employer Identification Number (EIN):**

*42-6001350*

**4. Plan Number:**

*501*

**5. Type of Plan:**

*Welfare benefit plan providing medical and prescription drug program.*

**6. Funding**

*The Plan is self-funded by Davenport Community School District #1611*

**7. Third Party Administrator:**

*UMR  
115 West Wausau Ave.  
Wausau, WI 54401-2875*

**8. Preferred Provider Organization:**

*United Healthcare Choice Plus Network  
115 West Wausau Ave.  
Wausau, WI 54401-2875*

**9. Pre-Certification, Utilization Review and Case Management Administrator:**

*UMR  
115 West Wausau Ave.  
Wausau, WI 54401-2875  
866-494-4502*

**10. Agent for Service of Legal Process:**

*Lane & Waterman  
220 N. Main Street  
Davenport, IA 52801*

Service of legal process may also be made upon the Plan Administrator.

**11. Sources of Contributions to the Plan:**

*The cost of providing benefits under the Plan is shared by the Employer, the Employees and the Retirees.*

**12. Fiscal Year of the Plan:**

*July 1 thru June 30th*

**13. Effective Date of the Plan:**

*July 01, 2000*

**14. Effective Date of Plan Restatement:**

*July 01, 2016*

## ***SCHEDULE OF BENEFITS***

### **DEDUCTIBLE AMOUNT (Calendar Year)**

	<u>PPO Network</u>	<u>Non-Network</u>
Individual	\$ 500	\$1,000
Family	\$1,000	\$2,000

***PPO Network and Non-Network deductibles are separate accumulations.***

### **DEDUCTIBLE**

The deductible amounts shown above are the amounts of eligible expenses which must be incurred during a Calendar Year by a Covered Person (for single coverage) or by a Covered Person and the Covered Person's dependents (for family coverage) before any eligible Expenses Incurred during that Calendar Year are payable. Please note that the Plan has separate deductible and out-of-pocket maximums for PPO Network Providers and Non-Network Providers. The separate accumulations for deductible and out-of-pocket maximums do not count toward each other. Should one or more Covered Persons of a family be injured in a common accident, only one deductible amount must be satisfied for the entire family for any eligible expense due to that accident.

### **DUAL COVERAGE UNDER THIS PLAN**

Deductible amounts applied under single coverage will be credited toward family coverage of the same individual. Deductible amounts applied under family coverage will be credited also under the single coverage of the individual. In no instance is the total deductible between the two coverages to exceed the maximum family deductible.

### **PREFERRED PROVIDER ORGANIZATION (PPO)**

United Healthcare Choice Plus Network.

### **BENEFIT PERCENTAGE AMOUNT (Calendar Year)**

#### *PPO Network Providers*

After eligible expenses reach the applicable deductible amount specified above, this Plan pays 90% of eligible expenses, unless otherwise indicated, up to the In-Network out-of-pocket maximum, and 100% thereafter to the maximum benefit while covered under the Plan. A "per visit" co-pay may also be required for specified services.

#### *Non-Network Providers*

After eligible expenses reach the applicable deductible amount specified above, this Plan pays 60% of eligible expenses, unless otherwise indicated, up to the Non-Network out-of-pocket maximum, and 100% thereafter to the maximum benefit while covered under the Plan.

Benefits for services provided by Non-Network Providers will be paid at the PPO Network benefit level and not subject to Reasonable and Customary when:

- A PPO Hospital/Facility/Physician is used but the emergency room Physician is a Non-Network Provider; or
- A PPO Hospital/Facility/Physician is used but the anesthesiologist, radiologist or laboratory are Non Network Providers; or



- The care provided is the initial care of a medical emergency; symptoms must occur suddenly and unexpectedly and must require prompt medical attention; or
- When services are not available within the network and a preauthorized referral is obtained prior to services being rendered. The preauthorization referral process must be completed with the Third Party Administrator.

*For Covered Persons outside the Network Area such as on vacation or business travel*

Eligible Expenses Incurred for Emergency Treatment by Covered Persons who travel outside the Network Area will be payable at the Network Providers benefit level when:

- The care provided is the initial care of a medical emergency; symptoms must occur suddenly and unexpectedly and must require prompt medical attention.
- This excludes any routine physical examination/immunization which must be provided by a PPO Network Provider to receive the PPO Network Providers benefit level.

*For Covered College Students Out-Of-Area*

Eligible Expenses Incurred by Covered Dependents who are enrolled in a full-time educational program outside the Network Area will be payable at the Network Providers benefit level. Usual and customary will not apply.

This excludes any routine physical examination/immunization which must be provided by a PPO Network Provider to receive the PPO Network Provider benefit level.

**OUT-OF-POCKET MAXIMUM (Calendar Year; includes deductible)**

	<u>PPO Network</u>	<u>Non-Network</u>
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000

*PPO Network and Non-Network Out-of-Pocket maximums are separate accumulations.*

The out-of-pocket maximum **does** include “per visit” office co-pays, but **does not include** prescription drug co-pays, ineligible charges, or charges above the Reasonable and Customary.

**MAXIMUM BENEFIT WHILE COVERED UNDER THE PLAN**

This Plan will pay an unlimited benefit for eligible expenses per Covered Person, so long as the person is covered under the Plan.

**TRANSPLANT NETWORK**

Organ transplant services must be performed at a Center of Excellence Transplant Facility contracted with the Third Party Administrator. Any transplant services from facilities not contracted as a Centers of Excellence Transplant Facility will be deemed ineligible expenses. More information on this benefit is in the “Eligible Medical Expenses” Section of this document.

## **BALANCE BILLING**

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are re-priced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over Non-Network Providers that engage in balance-billing practices.

In addition, with respect to services rendered by Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should be balance-billed for such difference.

Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such a practice is contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for payment of co-insurance, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

## **CLAIMS AUDIT**

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

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

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

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

## ***CARE MANAGEMENT***

### **PRE-CERTIFICATION / UTILIZATION REVIEW / CASE MANAGEMENT PROVIDER**

See the General Information section in the front of this booklet.

### **PRE-CERTIFICATION / UTILIZATION REVIEW**

The Pre-Certification / Utilization Review program will benefit you in several ways. You and your family will have professional confirmation that your proposed Hospital stay is truly necessary and that the treatment planned for you is the best possible option for your diagnosis. This assistance should remove much of the uncertainty that many of us feel when we are told that we need to go into the Hospital. Also, you will know that your Hospital stay will be as brief as possible, allowing you to return to the comfort of your home and family when you are medically able.

The goal is to keep your medical benefits at the high-quality level you expect, while ensuring that you are hospitalized only when it is absolutely necessary, and only for the minimum time needed.

In an effort to contain escalating costs, you, your dependents and your Physician should review and follow these important provisions:

- (1) Notify the pre-certification provider of any emergency hospitalization;
- (2) Notify the pre-certification provider in advance of any non-emergency Hospital admission;
- (3) Notify the pre-certification provider in advance before receiving any of the designated Outpatient procedures;
- (4) Notify the pre-certification provider in advance before receiving Organ Transplant services.

Pre-Certification / Utilization Review is a necessary provision in the event that you or your dependent(s) are admitted to the Hospital for an inpatient confinement. The attending Physician, you or your Covered Dependent(s) need to notify the Pre-Certification / Utilization Review Provider prior to the patient's admission to obtain authorization for the inpatient confinement. In case of emergency situations, it is the responsibility of the Physician, patient or patient's family to contact the pre-certification phone number within forty-eight (48) hours, or by the next working day if admission occurs over a weekend or holiday. If you or your dependent(s) are confined in a Hospital at the time coverage begins you are encouraged to notify the Hospital stay within forty-eight (48) hours of when coverage begins.

In the event that certain designated Outpatient procedures are being scheduled. The Outpatient procedures needing to be pre-certified are as follows:

- (1) CT Scan
- (2) MRI/MRA
- (3) Colonoscopy
- (4) PET Scan
- (5) Tonsillectomy and/or adenoidectomy (T & A)
- (6) Nasal Surgery (Septoplasty and Rhinoplasty)

The provisions of this Section do not apply to Maternity and Newborn benefits with regard to lengths of stay not in excess of forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a cesarean section.

**BENEFITS WILL BE DENIED FOR ANY HOSPITAL ADMISSION OR STAY WHICH IS NOT DETERMINED TO BE MEDICALLY NECESSARY.**

Organ Transplant services must be provided by a contracted Centers of Excellence Network Provider through the Third Party Administrator. No benefits are available if services are provided by a Non-Network Provider.

## **CASE MANAGEMENT**

Case Management is a service that helps people with short-term and long-term medical conditions. These conditions can be the result of a catastrophic event, a short-term medical need or the result of a chronic disease. The goals and benefits of Case Management services to you and your dependent(s) include the following:

- Increased understanding for your condition and, sometimes, the challenges that might continue for a long time or a lifetime.
- Collaboration and coordination with your health care providers (e.g., Physicians, therapy centers, treatment and diagnostic centers, home care services and medical equipment providers).
- Evaluation of care and service alternatives for ensuring you receive the right care at the right time and in the right place.
- Assistance in setting, monitoring and achieving health improvement goals that match each person's condition and needs.
- Empowerment through increased understanding for you for improved management of your medical condition and factors influencing your improvement.

## **CASE MANAGEMENT SERVICES**

Case Management Services include a broad range of programs, which include the following:

- Catastrophic Case Management – case management interventions in the event of catastrophic events – which may include a massive stroke, premature baby or spinal cord Injury.
- Short-term Case Management – case management interventions in the event home care needs (e.g., IV antibiotic therapy, nurse visits) are necessary after discharge from the Hospital.
- High Dollar Case Management – case management interventions for persons with a high risk for failure who utilize high cost and/or high volume medical services.
- Transplant Case Management – case management interventions for persons at risk or in the process (before and after) of an organ or tissue transplant.

It is important to remember, that while Case Management programs offer the services described above, your Physician is responsible for providing medical care.

## **HOW THE CASE MANAGEMENT PROGRAM WORKS**

Referrals to these programs are provided by claims information and also from the utilization management or the pre-certification process. You, your dependent(s) or your Physician can request Case Management services by contacting the Pre-Certification/Utilization Review/Case Management provider shown in the General Information section of this booklet. The toll free phone number is also listed on your identification cards.

Available information from claims and other benefit plan programs will be reviewed to evaluate whether or not Case Management services are appropriate. You will be contacted regarding your desire to participate in a Case Management program and your provider(s) will also be contacted for your medical information. Your information will remain secure and confidential and will only be used for treatment, healthcare operations and payment purposes.

If deemed appropriate, a nurse care coordinator will contact you regarding program participation. The program will be explained and you will be asked if you want to participate. If agreeable, a follow-up letter and consent for program participation will be sent to you. After an initial assessment, the nurse case coordinator will contact your providers to gather additional medical information to identify your needs and goals.

## ***ELIGIBLE MEDICAL EXPENSES***

Payment of benefits under this Plan is restricted to PPO Network Provider charges or Reasonable and Customary charges for items designated in this Plan as an “eligible expense;” provided the eligible expense is Medically Necessary, incurred for the treatment of Illness or accidental bodily Injury, and is not excluded by the terms of this Plan. See the “General Limitations” Section for provisions that may affect eligible expenses. Eligible expenses are as follows:

### **HOSPITAL EXPENSES**

The following are eligible expenses:

- (1) Room and Board Charges
  - (a) average semi-private rate;
  - (b) intensive care, cardiac care and isolation care;
  - (c) 90% of the private room rate if the facility contains no semi-private or ward rooms;
  - (d) special diet needs as Medically Necessary.
  
- (2) Miscellaneous Hospital Charges
  - (a) emergency room and Outpatient charges (observation care or care exceeding twenty-three (23) hours will be considered an in-patient admission);
  - (b) use of operating rooms, other surgical treatment rooms, burn care units, recovery and delivery rooms;
  - (c) diagnostic X-ray, radium and radioactive isotopes;
  - (d) all laboratory examinations, including typing of blood donors, and pathological laboratory services that are under the direction of a pathologist retained by the Hospital;
  - (e) pulmonary function evaluation;
  - (f) physical therapy treatment and intermittent positive pressure breathing;
  - (g) electroshock therapy, psychological testing including psychometric and other measuring tests;
  - (h) oxygen and other gas therapy;
  - (i) the use of durable medical equipment such as inhalators, suction machines, respirators, oxygen tents and hyperbaric oxygen chambers;
  - (j) prescription drugs, biologicals and solutions used while the Covered Person is in the Hospital;
  - (k) gauze, cotton, fabrics, solutions and other materials used in dressings and plaster casts;
  - (l) routine nursery care of a Newborn while the mother is Hospital confined;
  - (m) Necessary Services and Supplies for use in the Hospital, including surgically implanted devices that are provided and billed by the Hospital;
  - (n) intravenous injections and solutions; and
  - (o) other Medically Necessary services.

***PPO Network Providers:*** Eligible expenses paid at 90%, subject to the PPO Network deductible.  
(The deductible is waived for Outpatient PPO X-ray and Lab services).

***Non-Network Providers:*** Eligible expenses paid at 60%, subject to the Non-Network deductible.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

## CONVALESCENT HOSPITAL / EXTENDED CARE FACILITY / SKILLED NURSING FACILITY

This Plan will cover as an eligible expense services in a Convalescent Hospital / Extended Care Facility / Skilled Nursing Facility, if confined due to accidental Injury or Illness.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

The following are eligible expenses:

- (1) semi-private accommodations;
- (2) general nursing service, meals (including special diets);
- (3) use of special treatment rooms;
- (4) routine laboratory examination;
- (5) physical, occupational or speech therapy treatments;
- (6) oxygen and other gas therapy;
- (7) drugs, biologicals and solutions used while in the facility;
- (8) gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and casts;
- (9) the attending Physician certifies 24-hour care is necessary for recuperation from the Injury or Illness which required the Hospital Confinement and the Plan's Utilization Review provider has reviewed the services; and
- (10) this Plan may require written certification by the attending Physician as to the continuing need for skilled nursing care.

This Plan *will not* pay for:

- (1) charges in connection with drug addiction, chronic brain syndrome, alcoholism, mental retardation, senile deterioration or mental disorder; or
- (2) expenses excluded by any general limitation or provision set forth in this Plan.

## HOME HEALTH CARE

This Plan will cover as an eligible expense those expenses incurred as a result of Home Health Care. The Plan's Utilization Review provider may review Home Health Care services to confirm continuing medical necessity.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

The following are eligible expenses:

- (1) part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN) if the services of the RN are not available;
- (2) part-time or intermittent home health aide services which consist primarily of caring for the patient; and
- (3) physical therapy, occupational therapy, speech therapy and respiratory therapy;
- (4) laboratory services, medical supplies, medications and other medically necessary services.

This benefit *will not* pay for:

- (1) services or supplies not specified in the Home Health Care Plan;
- (2) services of a person who ordinarily resides in the Covered Person's home, is a member of the family or the Employee or spouse or services of a social worker;
- (3) transportation services; or
- (4) expenses excluded by any general limitation or provision set forth in this Plan.

## HOSPICE CARE

This Plan will cover as an eligible expense those expenses incurred by a terminally ill patient and rendered by a hospice either in the patient's home or a Hospice Facility. These services must be developed by a Hospice Care program in consultation and in agreement with the patient's Physician. The prognosis of the patient's Physician for the patient's life expectancy must be six (6) months or less.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

The following are eligible expenses:

- (1) Room and Board, including special diets;
- (2) services of a Physician, RN, LPN, home health aide, physical, occupational and respiratory therapist, psychiatrist, social worker;
- (3) drugs, nutritional supplements (enteral feedings only), medical supplies, laboratory tests, X-rays, diagnostic equipment, oxygen, durable medical equipment, and any other eligible expenses normally covered under this Plan; and
- (4) family counseling directly related to the patient's terminal condition, but not to exceed \$200.

This Plan *will not* pay for:

- (1) expenses for services of a person who resides in the patient's home or is a member of the patient's family;
- (2) expenses solely in connection with research;
- (3) expenses for services that do not meet medically acceptable standards of quality and sound principles of health care;
- (4) expenses related to the organization or dispensation of non-medical personal, legal or financial affairs, such as preparation of a will, liquidation of an estate, and other similar activities; or
- (5) expenses excluded by any general limitation or provision set forth in this Plan.

## THERAPY BENEFITS

This Plan will cover charges for services of physical, occupational and speech therapy, unless specifically excluded. Therapies are limited to sixty (60) combined days of service per Calendar Year.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

Eligible expenses include:

- (1) physical therapy as treatment of an Illness or Injury by physical means such as massage, hydrotherapy, heat or similar modalities. The treatment must be prescribed by a Physician and rendered by a Physician or licensed physical therapist working under the orders of a Physician;
- (2) occupational therapy provided by a licensed or registered occupational therapist; and
- (3) speech therapy if provided by a qualified speech therapist to restore speech loss or correct an impairment that is due to a congenital defect for which Surgery was performed, or an Illness (excluding Mental Illness) or Injury.

Providers of services must be licensed and operating in accordance with any applicable state laws.

## **SURGERY – PHYSICIAN SERVICES**

This Plan will cover as an eligible expense the professional services of an operating Physician including necessary pre- and post-operative care incurred as a result of an accidental Injury or Illness.

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

Surgical procedure means any procedure in the categories listed below:

- (1) the incision, excision or electro-cauterization of any organ or part of the body;
- (2) the manipulative redirection of a fracture or dislocation;
- (3) the suturing of a wound;
- (4) the removal by endoscopic means of a stone or other foreign object from the body;
- (5) invasive procedures, including but not limited to any scope procedure;
- (6) operative and cutting procedures for treatment of the mandible and/or maxilla; and
- (7) dental work or treatment only if incurred due to accidental Injury occurring to sound natural teeth, or in connection with oral surgery consisting of cutting procedures for the treatment of injuries of the jaw.

The surgical allowance will be determined in accordance with the Reasonable and Customary guidelines for the particular procedure in the geographical area in which the charge was performed. This Plan also will cover an assistant surgeon when services are rendered in connection with an eligible surgical procedure by other than an intern, a resident or an employee of the facility where Surgery is performed. This allowance will not exceed 20% of the primary surgeon's allowance.

If two or more surgical procedures are performed during the course of a single operation, the amount covered will be:

- (1) for two (2) or more procedures through the same incision: 100% for the major procedure and 50% for the remaining procedures; and
- (2) for two (2) or more procedures not performed through the same incision: as though separate operations were performed.

This Plan *will not* cover:

- (1) treatment of temporomandibular or craniomandibular joint syndrome when dislocation of the cartilage unless dislocation of the mandible is also present; dental or surgical treatment for mandibular or maxillary prognathism, malocclusion, etc.; surgical augmentation for orthodontics or maxillary or mandibular construction; or
- (2) any professional fees whatsoever other than the fees of the Physician or assisting surgeon for performing the surgical procedure; or
- (3) expenses excluded by any general limitation or provision set forth in this Plan.

## **SECOND SURGICAL OPINION BENEFIT**

This Plan will cover as an eligible expense the costs of a second surgical opinion from a Physician on the advisability of Surgery for a Covered Person. If this second opinion is in conflict with the first opinion, a third opinion can be sought and the cost is an eligible expense.

The following limitations will apply:

- (1) the Physicians furnishing the second and/or third surgical opinion must not be financially associated with each other or the Physician rendering the first opinion;
- (2) the Physicians must be board certified in the appropriate medical specialty or be recommended by a local medical society; and



- (3) the second opinion and, if needed, third opinion must be set forth in writing by the Physician after the patient has been examined.

This benefit *will not* pay for:

- (1) expenses for an opinion on a proposed surgical procedure that is not a covered procedure under this Plan;  
or
- (2) expenses excluded by any general limitation or provision set forth in this Plan.

#### **OUTPATIENT SURGERY – FACILITY**

This Plan will cover as an eligible expense those expenses rendered in connection with a surgical procedure performed in an Ambulatory Surgical Facility or Hospital Outpatient department to which the person is confined for less than twenty-three (23) hours. Observation care or care exceeding twenty-three (23) hours will be considered an in-patient admission.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

This benefit *will not* pay for:

- (1) expenses in connection with a surgical procedure that is normally and routinely performed in a doctor's office unless specified elsewhere in this Plan; or
- (2) expenses excluded by any general limitation or provision set forth in this Plan.

#### **MISCELLANEOUS EXPENSES**

It is recommended that Pre-Certification apply in the event that certain designated Outpatient procedures are being scheduled. See the “Pre-Certification / Utilization Review / Case Management” Section for additional information. The Outpatient procedures recommended to be pre-certified are as follows:

- (1) CT Scan
- (2) MRI/MRA
- (3) Colonoscopy
- (4) PET Scan
- (5) Tonsillectomy and/or adenoidectomy (T & A)
- (6) Nasal Surgery (Septoplasty and Rhinoplasty)

#### **MASTECTOMY**

As required by the Women’s Health and Cancer Rights Act of 1998, this Plan will make benefits available for the following Expenses Incurred in connection with a mastectomy:

- (1) reconstruction of the breast on which the mastectomy was performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) prostheses and physical complications in all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

Provided that this Plan is consistent with the Women’s Health and Cancer Rights Act of 1998, this benefit will not pay for expenses excluded by any general limitation or provision set forth in this Plan.

## ORGAN TRANSPLANT

All organ transplant services must be ordered by a PPO Network Provider, preauthorized by the Plan's Case Management Provider and received from a contracted *Center of Excellence Transplant Facility* or *benefits will not be paid*. This restriction applies to all services performed in conjunction with the transplant.

An approved transplant center participates in a transplant network contracted by the Plan's Third Party Administrator which gives the plan participants access to a wide range of organ transplant services through certification reviews and discounts on provider costs.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Not eligible.

Benefit payment for organ transplant services is subject to any maximums and limitations set for the benefit type rendered. For example, Hospital room benefits would be limited to a semi-private or intensive care room – a private room would not be covered unless approved as Medically Necessary.

Transplant services include all professional, technical and facility charges (Inpatient and Outpatient) for evaluation and the transplant procedure and follow-up care while the covered individual is covered under this Plan. All professional, technical and facility charges for a live donor are also covered if the donation is not covered by another plan.

Organ and tissues are covered for non-experimental transplants and include, but are not limited to, heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell. The PPO Network Provider must contact the pre-certification firm prior to the time services are rendered.

This Plan excludes any expenses in connection with or related to Experimental Treatments or services or which are performed solely for research purposes, or organ transplants which are experimental in nature.

## PHYSICIAN SERVICES

This Plan will cover as an eligible expense charges made for a Physician's services in the home, office, Hospital or free-standing medical center. This includes charges for diagnostic expenses and consultations but excludes telephone calls or visits in which the Physician does not see the Covered Person for treatment.

This Plan will also allow for the Physician's initial emergency first aid treatment, including necessary supplies and materials. A service will be considered emergency first aid if it is performed as a result of an acute medical emergency (life threatening) or an accidental bodily Injury.

### Office Visit

**PPO Network Providers:** Eligible expenses paid at 100% after a \$20 co-pay per office visit for Primary Care and Specialty Care Physicians. The Plan's PPO deductible does not apply. The co-pay includes office visit charges, Physician's services, and/or office lab and x-ray.

Primary Care Physicians are: Family Practice, General Practice, Internal Medicine, Obstetrical/Gynecological, Pediatrician, Doctor of Osteopath, Chiropractor, Nurse Practitioner and Physician Assistant.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

### **Surgical Procedures (Inpatient, Outpatient & Office)**

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

### **ROUTINE PHYSICAL EXAMINATION / IMMUNIZATION**

This Plan will cover as an eligible expense those Expenses Incurred for routine physical examinations (including well child exams), including charges for office visit, X-ray including annual routine or diagnostic mammogram screening, immunizations (including flu and pneumonia), and laboratory tests.

This Plan *will not* pay for expenses for immunization required for sports, insurance, employment or work-related requirements.

Adult and Child (age seven (7) and above) (other than Well Child): **Routine/Wellness (other than well-child) limited to one exam per calendar year.**

PPO Network Provider charges or Reasonable and Customary charges for routine physical examinations including charges for office visit, X-ray (including annual routine or diagnostic mammogram screening), immunizations (including flu and pneumonia), and laboratory tests.

**PPO Network Providers:** Eligible expenses paid at 100% after the \$20 co-pay, per office visit. The PPO deductible does not apply. Services for X-ray and laboratory tests related to the routine / wellness office visit will be covered with the office visit co-pay. Immunizations paid at 100% if no office visit charge applies.

**Non-Network Providers:** Not eligible.

This Plan *will not* pay for expenses for immunization required for travel, sports, insurance, employment or work-related requirements.

Well Child Care: **Well child care and well child immunizations through age six (6).**

**PPO Network Providers:** Eligible expenses paid at 100% after the \$20 co-pay, per office visit. The PPO deductible does not apply. Services for X-ray and laboratory tests related to the routine/wellness office visit will be covered with the office visit co-pay. Immunizations paid at 100% if no office visit charge applies.

**Non-Network Providers:** Deductible waived, eligible expenses paid at 60%.

### **DIAGNOSTIC X-RAY AND LAB**

This Plan will cover as an eligible expense those diagnostic X-ray and laboratory charges made in connection with an Illness or accidental Injury and recommended and approved by a Physician.

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

These expenses shall include:

- (1) electrocardiograms;
- (2) electroencephalograms;
- (3) radioisotope studies or scans;

- (4) laboratory tests; and
- (5) the professional reading, interpretation or administration of any covered X-ray or laboratory test.

In addition, this Plan will cover expenses for chemotherapy, radiation, radium, radon, roentgen, radioactive isotope or X-ray treatment when ordered by a licensed Physician and required because of Illness or Injury.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

### **INDEPENDENT LABORATORIES**

Benefits for services provided by Non-Network Providers will be paid at PPO Network benefit level when: PPO Network Provider utilizes an out-of-area laboratory for diagnostic purposes.

### **AMBULANCE SERVICE**

This Plan will cover as an eligible expense the services of a professional ambulance service (including medical air transportation service) to the nearest facility where emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.

**Network Providers and Non-PPO Network Providers:** Reasonable and Customary charges paid at 90%, subject to the PPO Network deductible.

### **MEDICAL SUPPLIES / DURABLE MEDICAL EQUIPMENT**

This Plan will cover as an eligible expense any rental or purchase of medical supplies required as a result of Illness or Injury (rental not to exceed the purchase price). Appliances or supplies must serve a medical purpose and have no other intrinsic value in the absence of an Illness or Injury.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the Network deductible.  
Prosthetic Limbs subject to a separate \$140 deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

The following are eligible expenses:

- (1) surgical supplies, including bandages, dressings, and appliances to replace physical organs or parts or to aid in their functions;
- (2) oxygen and rental of equipment for its administration;
- (3) functional prosthetic and orthopedic appliances (artificial limbs, braces, eyes, ears, noses);
- (4) orthopedic braces and/or crutches, but excluding corrective or special shoes;
- (5) medical equipment when prescribed by a Physician for no other purpose than for a medical reason.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

### **ANESTHESIA**

This Plan will cover as an eligible expense any expenses for anesthesia and its administration rendered in connection with an eligible surgical procedure when administered by an anesthetist, anesthesiologist, Physician or Registered Nurse (under the supervision of a Physician).

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

## MANIPULATION

This Plan will cover as an eligible expense treatment for musculoskeletal conditions.

**PPO Network Providers:** Eligible expenses paid at 100%, after the \$20 office visit co-pay.

**Non-Network Providers:** Reasonable and Customary charges paid at 90%, the deductible is waived.

## MENTAL HEALTH

This Plan will cover as an eligible expense the following Expenses Incurred for the treatment of Mental Health Disorders (subject to exclusion by any general limitation or provision set forth in this Plan).

### Inpatient

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

Residential Facility is limited to inpatient treatment at a Psychiatric Medical Institution for Children (PMIC) and for dependent children under age 18. Residential Facility services will be treated the same as a Hospital.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

### Outpatient

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

### Physician Office

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

**PPO Network Providers:** Eligible expenses paid at 100%, after the \$20 co-pay per office visit.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

For purposes of this provision only, services of a licensed social worker (LSW), when working under the direct supervision of a Physician, will be considered an eligible expense. This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

## SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY

This Plan will cover as an eligible expense the following Expenses Incurred for the treatment of Substance Abuse and Chemical Dependency (subject to any general limitations set forth in this Plan).

### Inpatient

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

### **Outpatient (Facility)**

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

### **Physician Office**

PPO Network Provider charges or Reasonable and Customary charges covered as any other Illness.

**PPO Network Providers:** Eligible expenses paid at 100%, after the \$20 co-pay per office visit.

**Non- Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

For purposes of this provision only, an Alcohol/Drug Abuse Treatment Facility (Residential and Non-Residential) shall be treated the same as a Hospital. This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

### **OTHER ELIGIBLE EXPENSES**

This Plan will cover the following as eligible expenses subject to any general limitation set forth in this Plan:

- (1) blood, blood plasma, and blood plasma expanders, and their administration;
- (2) services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- (3) kidney hemodialysis if not covered by Medicare; and
- (4) Outpatient contraceptive services other than prescription medication.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

### **ALLERGY INJECTIONS**

**PPO Network Providers:** Eligible expenses paid at 90%, deductible waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

### **ALLERGY TESTING / OFFICE VISIT / CONSULTATION**

**PPO Network Providers:** Subject to the \$20 per office visit co-pay, then Eligible expenses paid at 100%. The deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

### **ROUTINE IN-HOSPITAL NEWBORN CARE**

This Plan will cover as an eligible expense those Expenses Incurred for routine in-Hospital Newborn care for the Newborn of any Employee or dependent spouse covered under this Plan, as long as the mother is Hospital confined. This includes expenses for miscellaneous charges, doctor visits, and circumcision. (Charges billed by the Hospital for well Newborn Room and Board expenses and well Newborn miscellaneous diagnostic and laboratory expenses for the period during which the mother is Hospital confined are considered covered as an eligible expense under the Maternity Expenses benefit.)

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours or ninety-six (96) hours, as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

This Plan *will not* pay for:

- (1) expenses Incurred after the mother is discharged from the facility unless they are the result of an Illness or Injury;
- (2) expenses Incurred (miscellaneous charges, doctor visits and circumcision) if the Newborn child has not been added as a Dependent or is not deemed eligible as a Dependent according to the eligibility provisions of the Plan;
- (3) expenses Incurred for the Newborn of a dependent child; or
- (4) expenses excluded by any general limitation or provision set forth in this Plan.

#### **PRE-ADMISSION TESTING**

If a covered Employee or Covered Dependent is scheduled for an inpatient admission to a Hospital, this Plan will cover as an eligible expense any X-ray or laboratory charges incurred as a prerequisite of such admission and rendered on an Outpatient basis.

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

#### **MATERNITY EXPENSES**

Maternity expenses for any covered Employee or Dependent qualify as eligible expenses to the same extent as any other Illness. (Charges billed by the Hospital for well Newborn Room and Board expenses and well Newborn miscellaneous diagnostic and laboratory expenses for the period during which the mother is Hospital confined are considered covered as an eligible expense under the Maternity Expenses benefit.) For purposes of this provision only, a Birthing Center shall be treated the same as a Hospital.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a routine vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours or ninety-six (96) hours, as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

This Plan *will not* pay for expenses excluded by any general limitation or provision set forth in this Plan.

## **ACUPUNCTURE**

Acupuncture is defined as a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance and restoration of health the prevention of disease. Acupuncture will be eligible only if performed by an acupuncturist licensed for acupuncture services by the Board of Medical Examiners and in accordance with Section 148 E of the Iowa Administrative Code.

**PPO Network Providers:** Reasonable and Customary charges paid at 90%, the deductible is waived.

**Non-Network Providers:** Reasonable and Customary charges paid at 90%, the deductible is waived.

## **ROUTINE OR SCREENING COLONOSCOPY**

This benefit is subject to the guidelines approved by the American Cancer Society and Medicare guidelines. A routine or screening colonoscopy is covered every five (5) years for Covered Persons age 50 years and older. Pre-certification is required. Includes Physician charges, Facility charges, Anesthesia and Miscellaneous Lab and Pathology.

**PPO Network Providers:** Eligible expenses paid at 90%, the deductible is waived.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to Non-Network deductible.

## **DIABETIC SELF-MANAGEMENT PROGRAM**

This Plan will cover the treatment and/or services associated with equipment, supplies, and self-management training and education of all types of diabetes mellitus when prescribed by a physician. Benefits shall include:

- (1) Blood glucose meter and glucose strips for home monitoring;
- (2) Diabetes self-management training and education only under ALL of the following conditions:
  - (a) the physician managing the participant's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the participant's diabetic condition to ensure therapy compliance or to provide the participant with necessary skills and knowledge to participate in the management of the participant's condition; and
  - (b) the diabetes self-management training and education program is certified by the Department of Public Health. The program must meet the standard for certification of diabetes education programs as outlined by the American Diabetes Association.

Initial training shall cover up to ten hours of outpatient diabetes self-management training within a continuous twelve-month period and up to two hours of follow-up training for each subsequent year.

**PPO Network Providers:** Eligible expenses paid at 90%, subject to the PPO Network deductible.

**Non-Network Providers:** Eligible expenses paid at 60%, subject to the Non-Network deductible.

## **HEARING AIDS**

This Plan will cover expenses for Hearing Aid devices. Benefits will be limited to a maximum of \$1,500 every three (3) years. Includes one routine hearing aid examination per calendar year.

**PPO Network Providers:** Eligible expenses paid at 100%, after the \$20 office visit co-pay.

**Non-Network Providers:** Reasonable and Customary charges paid at 90%, the deductible is waived.



## ***PRESCRIPTION DRUGS***

Prescription drug benefits are exclusively provided through a network retained by the Plan. These network benefits may change from time to time. Presently, the following applies:

**Retail Pharmacy** (up to thirty-four (34) day supply or one hundred (100) units, whichever is less)

Generic: \$12 co-pay  
Brand: \$20 co-pay  
Specialty: \$25 co-pay

**Pharmacy By Mail Program** (up to ninety (90) day supply)

Generic: \$15 co-pay  
Brand: \$40 co-pay  
Specialty: \$45 co-pay

Mail order programs focus on maintenance drugs, such as those prescribed for chronic conditions, for example high blood pressure or diabetes. Maintenance drugs are typically prescribed for a long period of time and a known frequency.

The Pharmacy By Mail provider may dispense a minimum thirty-four (34) day to a maximum ninety (90) day supply of medication for each covered prescription or refill.

### **Non-Participating Pharmacy**

Not eligible.

**Note:** Prescriptions do not apply toward the Plan's Deductible or Out-of-Pocket Maximum.

### **Covered items:**

Legend drugs that are Medically Necessary. Medically Necessary means that the prescription drug provided by a Physician or pharmacy is required to diagnose or treat an Illness or Injury. The drug card provider determines whether a prescription drug is Medically Necessary. According to generally accepted medical practice, the prescription drug must be:

- (1) consistent with and appropriate for the treatment or diagnosis of the symptoms, Illness or Injury;
- (2) of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures;
- (3) the most appropriate and cost-effective prescription drug which can be safely provided to the patient; and
- (4) not chiefly for the convenience of the patient, patient's family or Physician or provider.

The fact that a prescriber has prescribed, ordered, recommended or approved a prescription drug, medication, test, device or supply does not in itself make it eligible for payment.

Certain prescription drugs are to be filled under the major medical portion of this Plan. Eligible expenses will be payable at 90% subject to the Plan's deductible. Those drugs include, but are not limited to:

- (1) growth hormone; and
- (2) items administered by a Home Health Care Agency (chemotherapy, nutritional therapy, IV therapy, etc.).

## ***GENERAL LIMITATIONS***

### ***EXCLUSIONS***

Notwithstanding any other provisions of this Plan to the contrary, eligible expenses will *not* include the following:

- (1) Expenses Incurred due to a work-related Injury or Illness sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit for which all or part of such expense is payable in accordance with the provisions of any Worker's Compensation or similar law;
- (2) Expenses Incurred that may be paid or reimbursed by any national, state, province, county or local government or any other political subdivision, instrumentality or agency thereof; except for Expenses Incurred by a veteran for a non-service-related disability in a facility operated by the United States government;
- (3) Expenses Incurred as a result of any Injury sustained or Illness contracted while on duty with any military, naval or air force of any country or international organization;
- (4) Expenses Incurred as a result of any Injury, Illness or disability caused by an act of war, commission of or attempted commission of an assault or a felonious act, involvement in insurrection or voluntary participation in a riot, nuclear explosion or nuclear accident. This exclusion does not apply if the Injury:
  - (a) resulted from being the victim of an act of domestic violence, or
  - (b) resulted from a documented medical condition (including both physical and mental health conditions);
- (5) Expenses Incurred solely because coverage exists or for which the patient has no legal obligation to pay, and Expenses Incurred prior to the period this Plan was effective;
- (6) Expenses Incurred for charges that are not Medically Necessary or are in excess of Reasonable and Customary charges as determined by industry standards;
- (7) Expenses Incurred for services performed by any member of a claimant's Immediate Family (spouse, parent, brother, sister or child) or a person who resides in the claimant's home;
- (8) Expenses Incurred for a routine physical examination not related to an Illness or Injury, such as a check-up or immunizations, except as specifically provided for elsewhere in this Plan;
- (9) Expenses Incurred for reduction of weight by diet control, any treatment of obesity not caused by an organic condition; diet programs, dietary supplements, nutritional formulas and supplements, nutritional counseling, and megavitamin therapy; surgical treatment and associated care for treatment of obesity, including any complications arising there from, except when it is determined that the patient meets the Plan's Utilization Review provider's established criteria for such treatment and the Plan's Utilization Review provider determines such treatment to be Medically Necessary;
- (10) Expenses Incurred for educational testing or training (except for diabetic education or training), or custodial or domiciliary care, rest cures, a place for the aged or a nursing home; Custodial care which means that care consists of watching, maintaining, protecting, or is for the purpose of providing personal needs rather than being able to cure. If the patient's condition requires care which is considered custodial, Plan benefits do not provide the following:
  - (a) assistance in the activities of daily living, such as walking, dressing, getting in and out of bed; bathing, eating, feeding or using toilet or help with other functions of daily living or personal needs of a similar nature.
  - (b) changes of dressings, diapers, protective sheets or periodic turning or positioning in bed.
  - (c) administration of, or help in using or applying, medications, creams and ointments, whether oral, inhaled, topical, rectal or injected.
  - (d) administration of oxygen.
  - (e) care or maintenance in connection with casts, braces or other similar devices.

- (f) care in connection with ostomy bags or devices or indwelling catheters.
  - (g) feeding by tube, including cleaning and care of the tube site.
  - (h) tracheostomy care, including cleaning, suctioning and site care.
  - (i) urinary bladder catheterization.
  - (j) monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function, including, but not limited to, a ventilator, phrenic nerve ordiaphragmatic pacer.
  - (k) general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitative services.
- (11) Expenses Incurred for biofeedback, holistic medicine, hypotherapy, vocational rehabilitation or employment counseling, marriage counseling, sex counseling, family counseling (except for services associated with hospice benefits), or behavioral training and related family counseling;
- (12) Expenses Incurred for charges that are in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for:
- (a) repair or alleviation of damage resulting from an Accident;
  - (b) because of infection or illness;
  - (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect.

A treatment will be considered cosmetic for either of the following reasons:

- (a) its primary purpose is to beautify; or
  - (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term cosmetic services includes those services which are described in IRS Code Section 213(d)(9).
- (13) Expenses Incurred for services or supplies rendered for eye examinations for the correction of vision, eye lenses (except for initial lenses following cataract Surgery), radial keratotomy, hearing examinations and hearing aids or fitting of same, except if specifically provided for elsewhere in this Plan;
- (14) Expenses Incurred for orthoptic training unless prescribed in writing by the attending Physician and performed by a fully licensed orthoptic technician or optometrist;
- (15) Expenses Incurred for Dental Services, except for:
- (a) Expenses incurred as a result of an Injury to sound natural teeth;
  - (b) the excision of a tooth root without the extraction of the entire tooth;
  - (c) closed or open reduction of a fracture or dislocation of the jaw;
  - (d) incision or excision procedures on the gums or tissues of the mouth when not performed in connection with tooth repair or extraction; or
  - (e) any dental procedure specifically provided for elsewhere in this Plan.
- (16) Expenses Incurred in connection with, or related to reverse sterilization procedures, including any complications arising there from;
- (17) Expenses Incurred for treatment of infertility, including but not limited to the following: artificial insemination, in-vitro fertilization and other artificial fertilization techniques, or reversal of voluntary sterilization procedures, including any complications arising there from;
- (18) Expenses Incurred in connection with or related to Experimental Treatments or services or which are performed solely for research purposes, or organ transplants which are experimental in nature;
- (19) Expenses Incurred for charges related to any domestic, personal or non-medical services or supplies;
- (20) Expenses Incurred for services or supplies for the removal of corns or calluses unless in conjunction with treatment of a metabolic or vascular disease; or for the treatment of flat, unstable or unbalanced feet unless surgery is required;

- (21) Expenses Incurred as a result of attempted suicide or an intentionally self-inflicted Injury. This exclusion does not apply if the Injury;
  - (a) resulted from being the victim of an act of domestic violence; or
  - (b) resulted from a documented medical condition (including both physical and mental health conditions).
- (22) Expenses Incurred for any routine or elective supplies such as, but not limited to: shoe inserts, ankle pads, printed material, arch supports, elastic stockings, fluoride, vitamins (even if prescribed in writing by a Physician), nutritional or dietary counseling, food supplements and any “over the counter” drug which can be purchased without a written prescription;
- (23) Expenses Incurred to the extent that a Covered Person is reimbursed, entitled to reimbursement, or is in any way indemnified for those expenses by or through any public program;
- (24) Expenses Incurred which are not for treatment of any accidental bodily Injury or Illness and are not Medically Necessary;
- (25) Expenses Incurred for drugs and medicines not prescribed by a Physician or not dispensed by a licensed pharmacist per the provisions established by the pharmacy manager, except as specifically provided for elsewhere in this Plan;
- (26) Expenses Incurred for the replacement or repair of wheelchairs, special Hospital beds, iron lungs and other mechanical devices required as a result of Illness or Injury;
- (27) Expenses Incurred for more than one replacement in a Calendar Year of trusses, braces, artificial limbs, artificial eyes, cataract glasses and prosthetic devices, except where replacement is required due to pathological change;
- (28) Expenses Incurred for speech therapy unless such therapy is rendered by a qualified speech therapist and is done to restore speech loss or correct an impairment that is due to either a congenital defect for which corrective Surgery was performed, or an Illness (excluding Mental Illness) or Injury; or
- (29) Expenses Incurred for services rendered outside the United States except for emergency medical treatment while on vacation, business travel or as an eligible student;.
- (30) Expenses Incurred for charges for care, supplies, treatment, and/or services that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation;
- (31) Expenses Incurred by the Participant after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation;
- (32) Expenses Incurred for charges that are charged solely due to the Participant’s having failed to honor an appointment;
- (33) Expenses Incurred that are for services, supplies, and/or treatment of any Participant that were incurred while confined and/or arising from confinement in a prison, jail or other penal institution;
- (34) Expenses Incurred for charges or portion of charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary or for services that is provided by a provider acting outside the scope of his or her license;
- (35) Expenses Incurred for genetic counseling or testing;
- (36) Expenses Incurred for massage therapy;
- (37) Expenses Incurred for non-medical treatment related to learning disabilities, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a learning disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
- (38) Expenses Incurred for charges that are expenses actually incurred by other persons.

## ***ELIGIBILITY OF COVERAGE***

### **Employee Coverage**

Any person who meets the definition of an "Employee" will be eligible for Employee coverage as follows:

- (1) Any such person who was covered under the group benefits Plan which was available through the Employer immediately prior to the effective date of this Plan shall become eligible for Employee coverage on the effective date of this Plan, provided such person is no longer eligible for benefits under the previous group benefits Plan and such loss of benefits was due solely to such Plan's termination; and
- (2) Any such person who is not eligible by virtue of (1) above who falls within one of the classifications set forth below shall become eligible for Employee coverage on the eligibility date indicated:
  - (a) The date specified by a master contract agreement; or
  - (b) The date specified by an employment contract, recommendation for hire or staff change; or
  - (c) The date specified by the Plan's Measurement Period for Variable Hour Employees, including temporary, substitute and seasonal Employees.

### **Dependent Coverage**

Each Employee who becomes eligible for Employee coverage shall become eligible for dependent coverage on the date the Employee becomes eligible for Employee coverage.

### **Special Enrollment Period**

An Employee and/or his Dependent(s) may be entitled to special enrollment in this Plan under the following circumstances.

- (1) Loss of Other Coverage
  - (a) The Employee and/or Dependent(s) were eligible but not enrolled in the Plan, and the Employee and/or Dependent(s) had other coverage which has now terminated because of loss of eligibility or loss of an employer contribution.
  - (b) The Employee and/or Dependent(s) were eligible but not enrolled in the Plan, and the Employee and/or Dependent(s) had other coverage under COBRA and the COBRA coverage has exhausted.

For the purposes of this section only, loss of eligibility for other coverage includes loss as a result of legal separation, divorce, death, termination of employment or reduction in work hours but does not include failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Enrollment for the eligible Employee and/or Dependent(s) will be effective on the day after the loss of other coverage, provided the Employee requests enrollment, by completing and submitting all enrollment materials otherwise required for coverage to become effective, within thirty (30) days of the special enrollment event.

- (2) Acquisition of a Dependent
  - (a) The Employee and/or Dependent(s) were eligible but not enrolled in the Plan, and the Employee gained a Dependent through marriage.

Enrollment for the eligible Employee and/or Dependent(s) will be effective on the date of marriage provided the Employee requests enrollment, by completing and submitting all enrollment materials otherwise required for coverage to become effective, within thirty (30) days of the special enrollment event.

- (b) The Employee and/or Dependent(s) were eligible but not enrolled in the Plan, and the Employee gained a Dependent through birth, adoption, placement for adoption, decree or court order.

Enrollment for the eligible Employee and/or Dependent(s) will be effective on the date of birth, adoption, placement for adoption decree or court order provided the Employee requests enrollment, by completing and submitting all enrollment materials otherwise required for coverage to become effective, within sixty (60) days of the special enrollment event.

(3) Children's Health Insurance Program (CHIP)

- (a) The Employee and/or Dependent(s) were eligible but not enrolled in the Plan, and the Employee and/or Dependent(s) loses coverage under Medicaid or a state child health program;
- (b) The Employee and /or Dependent(s) were eligible but not enrolled in the Plan, and the Employee and/or Dependent(s) become eligible for state assistance with respect to paying for Plan contributions.

Enrollment for the eligible Employee and/or Dependent(s) will be effective on the day after the loss of other coverage or the date approved for state assistance, provided the Employee requests enrollment, by completing and submitting all enrollment materials otherwise required for coverage to become effective, within sixty (60) days of the special enrollment event.

**Annual Open Enrollment Period**

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependent(s) for coverage under this Plan. Eligible Employees and/or their Dependent(s) who enroll during the annual open enrollment period will be considered Late Enrollees.

The annual open enrollment does not apply to Retirees and/or their Dependent(s).

If you and/or your Dependent(s) become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- (1) The Employer will give eligible Employees notice prior to the start of an annual open enrollment period; and
- (2) This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- (3) The Effective Date of coverage will be April 1<sup>st</sup> following the annual open enrollment period.

## Coverage Effective Dates

Any Employee eligible for Employee coverage or dependent coverage may obtain an enrollment application from the Employer. After completing the enrollment application, the Employee shall return it to the Employer. The Employer shall then provide the Third Party Administrator with a copy of the enrollment application.

Coverage under this Plan for which an Employee is eligible shall become effective on whichever of the following dates is applicable:

- (1) The date the Employee is first eligible for such coverage, if a completed enrollment application is submitted to the Employer on or before that date, or within thirty (30) days following the date the Employee was first eligible for such coverage;
- (2) With respect to an individual enrolled during a Special Enrollment Period, the day after the loss of other coverage, provided the Employee requests enrollment by completing and submitting all enrollment materials otherwise required for coverage to become effective within thirty (30) days of the special enrollment event; sixty (60) days if due to loss of Medicaid or state child health program.
- (3) With respect to a Dependent acquired by an Employee through marriage, birth, adoption, placement for adoption, decree or court order, the date such Dependent is acquired, provided the Employee requests enrollment by completing and submitting all enrollment materials otherwise required for coverage to become effective, within thirty (30) days of the date of marriage, sixty (60) days from the date of birth, adoption, placement for adoption, decree or court order.
- (4) With respect to a Dependent child resuming full-time student status, coverage will be effective the first day of class as long as the written request for enrollment is completed within 30 days of the first day of class.

In situations where Dependent Coverage is already in effect prior to the date a Dependent is acquired pursuant to paragraph (3) above, the thirty (30) day or sixty (60) day period described above shall be deemed satisfied, provided that the Employee completes the proper enrollment forms within a reasonable time after acquiring the Dependent. Although the effective date will not be delayed, no claims will be processed under the Plan until the Dependent is properly enrolled.

The following shall apply as exceptions to the preceding coverage effective dates:

- (1) If the Employee is not actively at work on the date his employee benefits would otherwise become effective, his employee benefits shall not become effective until the first date thereafter that he is actively at work;
- (2) No dependent benefits (including any dependent benefits for which an individual enrolls during a Special Enrollment Period) shall become effective for an Employee unless he is covered, or simultaneously becomes covered, for employee benefits;
- (3) Coverage for legally adopted children, other than adopted newborn children, will begin on the date of placement in the residence of the covered Employee provided that the Plan Administrator has received the completed enrollment application before or within sixty (60) days after the date the child was placed. Coverage for adopted newborn children will begin the earlier of:
  - (a) The moment of birth, provided that a written agreement to adopt such child has been entered into by the covered Employee prior to the birth of the child and the Plan Administrator has received the completed enrollment application before or within sixty (60) days of the date of the birth of the child; or

- (b) The date the adopted newborn child is placed in the residence of the covered Employee provided that the Plan Administrator has received the completed enrollment form before or within sixty (60) days after the date the child was placed.

There will be no coverage for the newborn under this Plan if the newborn is not ultimately placed in the residence of the covered Employee. For all children covered as adopted children, if the final Decree of Adoption is not issued, coverage for the proposed adopted child shall not be continued under this Plan beyond the date that adoption proceedings are discontinued. It is the responsibility of the covered Employee to notify the Plan Administrator if the adoption does not take place. Proof of adoption will be required by the Plan Administrator.

### **Qualified Medical Child Support Order**

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

- (1) An order which purports to be a QMCSO must be served on the Plan's agent for service of legal process ("Agent").
- (2) Within ten (10) days of the receipt of such an order, the Agent shall deliver the order to the Third Party Administrator.
- (3) The Third Party Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO.
- (4) An order which, in the judgment of the Third Party Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.
- (5) When the Third Party Administrator makes a preliminary determination that an order satisfies the requirements of QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.
- (6) The Third Party Administrator shall notify all parties involved, including a designated representative of the Covered Dependent, of the Employer's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Plan pursuant to a Qualified Medical Child Support Order may be made to the Covered Dependent or the Covered Dependent's custodial parent.



## ***TERMINATION OF COVERAGE***

### **Termination of Employee Coverage**

The coverage of any Covered Person with respect to himself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the occurrence of one of the following events:

- (1) On the last day of the month in which employment terminates;
- (2) On the last day of the month in which the covered Employee has failed to make a required Employee contribution;
- (3) On the last day of the month in which the covered Employee fails to continue to satisfy eligibility requirements;
- (4) On the last day of the month in which the covered Employee enters the military, naval or air force of any country or international organization on a full-time active duty basis, other than scheduled drills or other training not exceeding one month in any calendar year; or
- (5) On the termination date of this Plan.

### **Termination of Dependent Coverage**

Dependent coverage will terminate on the earliest of the following:

- (1) On the last day of the month the covered Employee's coverage terminates;
- (2) On the last day of the month in which the covered Employee has failed to make any required contributions for Dependent coverage;
- (3) On the last day of the month the covered Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis, other than scheduled drills or other training not exceeding one month in any calendar year;
- (4) On the last day of the month in which the covered Employee ceases to be in a class providing for Dependent coverage;
- (5) On the last day of the month in which the covered Dependent ceases to qualify under the definition of Dependent;
- (6) On the date the covered Dependent qualifies as an Employee eligible for Plan coverage;
- (7) On the date Dependent coverage is terminated under this Plan; or
- (8) On the termination date of this Plan.

## ***EXTENSION OF BENEFITS / CONTINUATION OF BENEFITS***

### **EXTENSION OF BENEFITS**

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the "Continuation of Benefits" provisions below, benefits under the Plan may nevertheless be extended under the specific circumstances enumerated herein. Any extension of benefits period pursuant to this Section shall postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to "Continuation of Benefits" Section below.

(1) ***Eligible Retiree Continuation***

An Employee who retires prior to age sixty-five (65), is at least fifty-five (55) years of age, and has met the eligibility requirements as established by the Iowa Public Employees Retirement System (IPERS), and was covered under the Plan immediately prior to retirement, may continue coverage at the retired Employee's own expense under the Plan until the date the retired Employee reaches age sixty-five (65). These individuals will be considered as "Retirees" for purposes of this Plan. This will also include Employees who retire because of a disability and begins receiving federal Social Security Disability or Railroad Retirement Disability benefits.

This extension also applies to the Retiree's Eligible Dependent(s). The Retiree's Dependent(s) will be eligible for COBRA continuation of coverage when the Retiree becomes eligible for Medicare or if the Retiree dies before becoming eligible for Medicare.

(2) ***State Mandates, Collective Bargaining Agreements Or Employer Personnel Policies***

If coverage under the Plan would otherwise terminate with respect to an Employee or Covered Dependent, the Employee may continue coverage at the Employee's own expense for the Employee and his Covered Dependent(s) to the extent required by a state law, a collective bargaining agreement in effect with respect to the Employer, or the Employer's personnel policies.

### **CONTINUATION OF BENEFITS - COBRA**

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions. The COBRA continuation coverage provisions of the Plan shall be administered in accordance with the requirements of Section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA) and any statutes or regulations that extend or amend the provisions of ARRA.

For the purpose of this Section, "Qualified Beneficiary" generally includes any Covered Person whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. In addition, the term "Qualified Beneficiary" shall also mean any child born to or placed for adoption with the Covered Person during the period of continuation coverage described in this Section, provided such child qualifies as an eligible Dependent.

(1) ***Eligibility To Make Election***

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

- (a) The Covered Person's death;
- (b) Termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntarily or involuntarily);

- (c) Divorce or legal separation of the Covered Person and his spouse;
- (d) The Covered Person becoming entitled to Medicare benefits; or
- (e) A Covered Person's child ceasing to be an Eligible Dependent.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person's termination of employment is for gross misconduct as determined by the Employer in its sole discretion, pursuant to a uniform, nondiscriminatory policy.

(2) ***Election Period And Procedure***

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending sixty (60) days after the later of (i) such date, or, (ii) if applicable under "Administration" Subsection, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election.

(3) ***Benefits***

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances are otherwise entitled except (e.g., life, ad&d, disability or any other income replacement plans). If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

(4) ***Payment For Benefits***

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing or reelecting such continuation coverage.

(5) ***Duration of Continuation Coverage***

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

- (a) The date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;
- (b) The date thirty-six (36) months after the date of any other event described in "Eligibility to Make Election" Subsection other than a Covered Person's termination of employment or reduction in hours
- (c) The date the Employer ceases to provide any health benefit for plan any of its Employees;

- (d) The date the Qualified Beneficiary becomes covered (as an Employee or otherwise) by another group health plan which does not contain any exclusion or limitation, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;
- (e) The date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (including any grace period if the Employer establishes such a period) as determined by the Employer;
- (f) In the case of an individual who is a Qualified Beneficiary by reason of having been the Participant's spouse, the date the Qualified Beneficiary remarries and becomes covered under another health benefit plan which does not contain any exclusion or limitation; or
- (g) In the case of an individual who is determined, under Title II or XVI of the Social Security Act, to have been disabled within sixty (60) days of a qualifying event (as described in "Eligibility to Make Election" Subsection herein), the earlier of (i) the date twenty-nine (29) months after the date of occurrence of such event, but only if the Qualified Beneficiary has provided notice of such determination within sixty (60) days after the date of determination, and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event, or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in "Eligibility to Make Election" Subsection herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Subsection. In addition, the maximum period available for continuation coverage pursuant to this "Continuation of Benefits" Section is measured from the date of occurrence of the qualifying event specified in "Eligibility to Make Election" Subsection, and is not delayed or extended by any extension of benefits period available pursuant to "Extension of Benefits" Section above.

Notwithstanding anything in this Section to the contrary, in the case of the Covered Person's termination of employment (other than by reason of such Employee's gross misconduct) or reduction of his hours that occurs less than eighteen (18) months after the date the Covered Person became eligible for benefits under Title XVIII of the Social Security Act, the period of coverage under this "Continuation of Benefits" Section for any Qualified Beneficiary, other than the Covered Person, shall not terminate before the close of the thirty-six (36) month period beginning on the date the Covered Person became entitled to such benefits.

(6) ***Administration***

- (a) **Notice on Death, Termination, Reduction of Hours, or Eligibility for Medicare**  
Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours, or eligibility for Medicare, the Employer shall inform the plan administrator that the Qualified Beneficiaries may be eligible to elect continuation coverage. The Employer or plan administrator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer.
- (b) **Notice of Change in Marital Status or Dependent Status**  
If a Covered Person becomes divorced or legally separated, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he is no longer an eligible Dependent, either the Covered Person, the Covered Person's spouse or the Covered Person's child must notify the Employer of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce or legal separation, the Employer, if notified within the time period specified in this Section, shall notify the other Qualified Beneficiaries of their eligibility to elect continuation coverage.

(c) General

- (i) Multiple Events: If more than one event described in "Eligibility to Make Election" Subsection occurs, the first such event occurring will determine which one of either Subsection (i) or (ii) of this Subsection (c) is applicable.
- (ii) Interpretation: In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted and administered in a manner which meets the minimum requirements of COBRA.

## **FAMILY AND MEDICAL LEAVE**

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Employees and their Dependents under certain specified conditions.

An Employee who takes a Leave of Absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his Dependent(s). Benefits under the Plan are available to the same extent as if the Employee had been Actively At Work during the entire leave period, subject to the following terms and conditions:

- (1) Coverage shall cease for an Employee and his Dependent(s) for the duration of the leave if at any time the Employee is more than thirty (30) days late in paying any required contribution.
- (2) An Employee who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period or physical examination.
- (3) If an Employee who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Employee advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
- (4) Any portion of the cost of coverage which had been paid by the Employee prior to the leave, must continue to be paid by the Employee during the leave. If the cost is raised or lowered during the leave, the Employee shall pay the new rates. If the leave is unpaid, the Employee and the Employer shall negotiate a reasonable means for paying the Employee's portion of the cost.
- (5) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Employee is on leave, the Employee is entitled to the new or changed plan and benefits to the same extent as if the Employee were not on leave.
- (6) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Employee fails to return to work after the Employee's leave entitlement has been exhausted or expires, unless the reason the Employee does not return to work is due to:

- (a) the continuation, recurrence, or onset of a serious health condition which would entitle the Employee to additional leave under FMLA; or
- (b) other circumstances beyond the Employee's control. If an Employee fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Employee's behalf during a period of unpaid leave, the Employer may require medical certification of the Employee's or the Dependent's serious health condition. The Employee is required to provide medical certification within thirty (30) days from the date of the Employer's request. If the Employer requests medical certification and the Employee does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

## **MILITARY LEAVE**

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the "Continuation of Benefits" Section described above.

### **(1) *Election And Duration Of Coverage***

A Covered Person may elect to continue coverage under the Plan for himself and his Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

- (a) The eighteen (18) month period beginning on the date on which the Covered Person's military leave began; or
- (b) The day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

### **(2) *Benefits***

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same benefits as provided to all other Covered Persons and Covered Dependents. If benefits under the Plan are increased, decreased or otherwise amended or changed, either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

### **(3) *Payment For Benefits***

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing or reelecting such continuation coverage.

(4) ***Employee Returning From Military Leave***

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his Eligible Dependent(s) shall again be eligible for coverage under the Plan immediately upon the Covered Person's return to employment with the Employer. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his Eligible Dependent(s) to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Illness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

## ***ADMINISTRATION***

### **ASSIGNMENT**

Benefits under this Plan may be assigned to a provider upon written authorization of the Covered Person or Covered Dependent.

### **WITHHOLDING OF BENEFIT PAYMENTS**

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Third Party Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Third Party Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

### **MEDICAL EXAMINATION**

The Third Party Administrator shall have the right, through a Physician of its choice, to examine an Employee or Eligible Dependent as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Third Party Administrator shall be entitled to receive any and all reports regarding such examinations or autopsies.

### **RIGHT TO RECEIVE AND RELEASE INFORMATION**

The Third Party Administrator, pursuant to the reasonable exercise of its discretion, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Third Party Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. Any claimant under this Plan shall furnish to the Third Party Administrator such information as may be necessary to carry out this provision.

### **FACILITY OF REIMBURSEMENT**

If payments which should have been made under this Plan as stated in this provision have been made under any other plan or plans, the Third Party Administrator may, at its sole option, pay to any organizations making such other payments any amounts which it determines will satisfy the intent of this provision. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Third Party Administrator shall be fully discharged from liability under this Plan.

### **RECOVERY OF PAYMENTS**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pay benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person on whose behalf such payment was made.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand.



The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied. The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum.

When a Covered Person or other entity does not comply with the provisions of the section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Persons are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another part's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- (6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupation Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under the Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment of benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

## SUBROGATION AND REIMBURSEMENT PROVISION

### (1) *Payment Condition*

- (a) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, personal representative, guardian or assigns (collectively referred to hereinafter in this section as “Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).
- (b) Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits in constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.
- (c) In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
- (d) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

### (2) *Subrogation*

- (a) As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.
- (b) If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable cost of collection.
- (c) The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

- (d) If the Participant(s) fails to file a claim or pursue damages against:
  - (i) The responsible party, its insurer, or any other source on behalf of that party;
  - (ii) Any first party insurance through medical payment coverage, personal injury protection, no fault coverage, uninsured or underinsured motorist coverage;
  - (iii) Any policy of insurance from any insurance company or guarantor of a third party;
  - (iv) Workers' compensation or other liability insurance company; or
  - (v) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

(3) ***Right of Reimbursement***

- (a) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s) recovery is less than the benefits paid, the Plan is entitled to be paid all of the recovery achieved.
- (b) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- (c) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, and lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (d) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgement of these rights is required by the Plan and signed by the Participant(s).
- (e) The provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

(4) ***Excess Insurance***

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

The Plan's benefits shall be excess to:

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

(5) ***Separation of Funds***

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

(6) ***Wrongful Death***

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

(7) ***Obligations***

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

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

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

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

(8) ***Offset***

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

(9) ***Minor Status***

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

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

(10) ***Language Interpretation***

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

(11) ***Severability***

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

## **COORDINATION OF BENEFITS**

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Illness or Injury. The other plans are those which provide benefits or services for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the Expenses Incurred. One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable Expenses Incurred.

No plan will pay more than it would have paid without this special provision. The following rules apply to determine which plan is Primary and which plan is Secondary:

- (1) If one plan has no coordination of benefits provision, it is automatically Primary.

- (2) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual as a Dependent.
- (3) If an individual is covered as a Dependent under two or more plans, the plan which covers the individual as a Dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.
- (4) In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is primary.
- (5) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual:
  - (i) as a former Employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to the "Continuation of Benefits" Section herein.
- (6) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Information necessary to the administration of this provision will be required at the time a claim is submitted.

#### **COORDINATION WITH MEDICARE AND MEDICAID**

(1) ***Medicare***

This Plan will be considered the Primary Plan for Covered Persons who are current Employees and their Covered Dependents who are nevertheless eligible for Medicare benefits if: (i) such Covered Persons or Covered Dependents are age sixty-five (65) or older and their Employer employs twenty (20) or more Employees, or (ii) such Covered Persons or Covered Dependents are disabled and any Employer under this Plan employs one hundred (100) or more Employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the Primary Plan for all other Covered Persons and Covered Dependents, unless the Covered Persons or Covered Dependents reject coverage under this Plan.

(2) ***Medicaid***

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Persons or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

## ***CLAIM PROVISIONS***

### **ANNUAL INFORMATION STATEMENT**

An annual information statement must be completed each year by the Covered Person and properly signed as required by the Employer. The completed form must be submitted to the Third Party Administrator. The procedures outlined below must be followed by Covered Persons and Covered Dependents (“claimants”) to obtain payment of benefits under the Plan.

### **BENEFIT CLAIMS**

(1) ***Discretion of Plan Administrator***

All claims must be must be filed with the Third Party Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Third Party Administrator or other appropriate entity as directed by the Plan Administrator, provided, however, that the Third Party Administrator or other appropriate entity, is not a Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

(2) ***When Claims Must Be Filed***

Claims must be filed with the Third Party Administrator within ninety (90) days of the date charges for the service was incurred. Failure to file claims within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish the claims within that time, provided such proof is furnished as soon as reasonably possible and in no event later than one (1) year from the time the claims are otherwise required. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan’s procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92 or other approved standardized method:

- (a) The date of service;
- (b) The name, address, telephone number and tax identification number of the provider of the services or supplies;
- (c) The place where the services were rendered;
- (d) The diagnosis and procedure codes;
- (e) The amount of charges;
- (f) The name of the Covered Person; and
- (g) The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within forty-five (45) days from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being denied or reduced.**

(3) ***Timing of Claim Decisions***

The Third Party Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre - Service Claims, of decisions that a claim is payable in full) within the following timeframes:

(a) Pre-Service Claims

- (i) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
- (ii) If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Third Party Administrator and the claimant (if additional information was requested during the extension period).

(b) Post-Service Claims

- (i) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
- (ii) If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Third Party Administrator and the claimant.

(c) Extensions – Pre-Service Claims

This period may be extended by the Plan for up to fifteen (15) days, provided that the Third Party Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(d) Extensions – Post-Service Claims

This period may be extended by the Plan for up to fifteen (15) days, provided that the Third Party Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(e) Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.



(4) ***Notification of an Adverse Benefit Determination***

The Third Party Administrator shall provide a claimant with a notice, either in writing or electronically containing the following information:

- (a) A reference to the specific portion(s) of the Plan upon which a denial is based;
- (b) Specific reason(s) for a denial;
- (c) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on final review;
- (e) 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 claimant's claim for benefits;
- (f) The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- (g) Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and
- (h) In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental Treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

**APPEALS OF ADVERSE BENEFIT DETERMINATIONS**

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- (1) Claimants at least one hundred eighty (180) days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and sixty (60) days to appeal a second adverse benefit determination;
- (2) Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- (3) For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named Fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- (4) For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- (5) That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- (6) For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
- (7) That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

## FIRST APPEAL LEVEL

### (1) *Requirements for First Appeal*

The claimant must file the first appeal in writing within one hundred eighty (180) days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be sent to the Third Party Administrator as shown in the General Information section.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- (a) The name of the Employee/claimant;
- (b) The Employee/claimant's social security number;
- (c) The group name or identification number;
- (d) All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
- (e) A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- (f) Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

### (2) *Timing of Notification of Benefit Determination on First Appeal*

The Third Party Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- (a) For Pre-Service Claims, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the appeal.
- (b) For Post-Service Claims, within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

- (c) The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(3) ***Manner and Content of Notification of Adverse Benefit Determination on First Appeal***

The Third Party Administrator shall provide a claimant with notification in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific portion(s) of the Plan on which the denial is based;
- (c) The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- (d) 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 claimant's claim for benefits;
- (e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- (f) If the adverse benefit determination is based upon a medical judgment, a statement that 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 upon request;
- (g) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
- (h) A description of the Plan's review procedures and the time limits applicable to the procedures;
- (i) A statement of the claimant's right to bring an action, following an adverse benefit determination on final review; and
- (j) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

(4) ***Furnishing Documents in the Event of an Adverse Determination***

In the case of an adverse benefit determination on review, the Third Party Administrator shall provide such access to, and copies of, documents, records, and other information described in Subsections (c) through (f) of this Subsection (3) relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

## **SECOND APPEAL LEVEL**

(1) ***Adverse Decision on First Appeal; Requirements for Second Appeal***

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has sixty (60) days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing and must include all of the items set forth in the Section entitled "Requirements for First Appeal."

(2) ***Timing of Notification of Benefit Determination on Second Appeal***

The Third Party Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- (a) For Pre-Service Claims within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the second appeal.
- (b) For Post-Service Claims within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(3) ***Manner and Content of Notification of Adverse Benefit Determination on Second Appeal***

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the Section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

(4) ***Furnishing Documents in the Event of an Adverse Determination***

In the case of an adverse benefit determination on the second appeal, the Third Party Administrator shall provide such access to, and copies of, documents, records, and other information described in Subsections (c) through (f) of the Section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

(5) ***Decision on Second Appeal to be Final***

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Third Party Administrator or other appropriate named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's claim review procedures have been exhausted.**

## **EXTERNAL REVIEW PROCEDURES**

- (1) The Third Party Administrator shall notify the Plan of claims denied where such claims are:
  - (a) Denied based upon a lack of medical necessity as that term is defined by the Plan; and
  - (b) Appealed by the participant or beneficiary to the Plan pursuant to the terms of the Plan, and the original denial is upheld.
- (2) The Plan shall examine such claims and information submitted therewith and make a final determination of the eligibility of such claims for reimbursement under the Plan.
- (3) If such final determination is adverse to the participant or beneficiary, the Plan shall cause the Third Party Administrator to provide notice to the participant or beneficiary of the Plan's determination and the participant's or beneficiary's right to external review pursuant to Section 514J of the Iowa Code.

Once the Plan receives notice that the Insurance Commissioner has certified the request for external review, the Plan shall either:

- (a) Contest such certification within three (3) business days if the Plan believes that such certification was in error; or
  - (b) Comply with the following external review procedures.
- (4) Within three (3) business days of receipt of a certified request for external review from the Insurance Commissioner, the Plan shall:
- (a) Select an independent review entity from the list certified by the Commissioner of Insurance;
  - (b) Notify the provider and participant or beneficiary of the name, address and phone number of the independent review entity and of the provider's and participant's or beneficiary's right to submit additional information;
  - (c) Provide any information submitted to the Plan by the provider, participant or beneficiary in support of the request for coverage pursuant to the Plan's appeal procedure; and
  - (d) Provide any other relevant documents used by the Plan in determining whether such claims were eligible for reimbursement under the Plan.
- (5) Upon receipt of the decision of the independent review agency, the Plan shall either;
- (a) Comply with the independent review agency's determination, or
  - (b) File for judicial review in the appropriate court of law.

#### **APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

#### **FACILITY OF PAYMENT**

If a Covered Person dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Third Party Administrator may, at its option, make direct payments to the individual or institution on whose charges claim is based or to the surviving spouse of the Covered Person, or if none, to his surviving child or children (including legally adopted child or children) share and share alike, or if none, to the executors or administrators of the Covered Person's estate.

#### **MINOR OR INCOMPETENCY**

If a Covered Person is a minor or, in the opinion of the Third Party Administrator, not competent to give a valid receipt for payment of any benefit due him under the Plan and if no request for payment has been received by the Third Party Administrator from a duly appointed guardian or other legally appointed representative of that person, the Third Party Administrator may, at its option, make direct payment to the individual or institution appearing to the Third Party Administrator to have assumed the custody or the principal support of that person.

#### **DISCHARGE**

Any payment by the Third Party Administrator in accordance with these provisions will discharge the Employer and the Third Party Administrator from all further liability to the extent of the payment made.

**TIME LIMITATIONS**

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

## ***MISCELLANEOUS***

### **NONALIENATION OF BENEFITS**

Benefits payable under this Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Covered Person or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

### **INVALID PROVISION**

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

### **GOVERNING LAW**

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Iowa where it has been executed, except where preempted by federal law.

### **AMENDMENT/TERMINATION**

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Covered Person or Covered Dependent shall have become entitled prior to such amendment or termination of the Plan.

### **EXCLUSIVE BENEFIT/LEGAL ENFORCEABILITY**

The Plan has been established, and is being maintained, for the exclusive benefit of the Employees of the Employer. The Plan terms as provided herein are legally enforceable by the Employees.

### **GRANDFATHERED HEALTH PLAN DISCLOSURE**

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov). In addition, the following website has additional information regard grandfathered health plans: <https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>.

## ***NOTICE OF PRIVACY PRACTICES***

This Notice of Privacy Practices (“Notice”) applies to Protected Health Information (defined below) associated with the Davenport Community School District #1611 Employee Health Benefit Plan provided by the Davenport Community School District #1611 to its Employees, its Employee’s Dependents and, as applicable, retired Employees. This Notice describes how the Davenport Community School District #1611, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. This Notice is effective as shown on the cover of such document.

### **DEFINITIONS**

- (1) **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information (“PHI”) or Electronic Protected Health Information (“ePHI”) that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- (2) **Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

### **COMMITMENT TO PROTECTING HEALTH INFORMATION**

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant’s PHI, and inform him/her about:

- (1) The Plan’s disclosures and uses of PHI;
- (2) The Participant’s privacy rights with respect to his/her PHI;
- (3) The Plan’s duties with respect to his/her PHI;
- (4) The Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
- (5) The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set for in 45 CFR Sections 160.103 and 164-501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

### **HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED**

In general, the Privacy Rules permit the Plan to use and disclose the minimum necessary amount, an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

- (1) To carry out Payment of benefits;
- (2) For Health Care Operations;
- (3) For Treatment purposes; or



- (4) If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

## **DISCLOSURE OF PHI TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES**

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Establish safeguards for information, including security systems for data processing and storage;
- (4) Maintain the confidentiality of all PHI, unless and individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
- (5) Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
- (6) Not use or disclose genetic information for underwriting purposes;
- (7) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
- (8) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (9) Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- (10) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
- (11) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
- (12) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- (13) Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
- (14) Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
- (15) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (16) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504 (f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - (a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed
    - (1) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

- (b) In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

#### **DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR**

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

#### **DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR**

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

#### **DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE**

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

#### **PRIMARY USES AND DISCLOSURES OF PHI**

- (1) Treatment, Payment and Health Care Operations: The plan has the right to use and disclose a Participant’s PHI for all activities as included with the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
- (2) Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant’s information; and
- (3) Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

#### **OTHER POSSIBLE USES AND DISCLOSURES OF PHI**

- (1) Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
- (2) Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

- (a) A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
  - (b) Report reactions to medications or problems with products or devices regulated by the Federal Food And Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
  - (c) Locate and notify person of recalls of products they may be using; and
  - (d) A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law.
- (3) The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representative although there may be circumstance under Federal or State law when the parents or other representative may not be given access to the minor's PHI;
- (4) Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
- (5) Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
- (6) Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
- (7) Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
- (8) Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
- (9) To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
- (10) Workers' Compensation: The plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
- (11) Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

## **REQUIRED DISCLOSURES OF PHI**

- (1) Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the participant; and

- (2) Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

## **INSTANCES WHEN REQUIRED AUTHORIZATION IS NEEDED FROM PARTICIPANTS BEFORE DISCLOSING PHI**

- (1) Uses and disclosure for marketing;
- (2) Sale of PHI;
- (3) Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

## **PARTICIPANT'S RIGHTS**

The Participant has the following rights regarding PHI about him/her:

- (1) Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
- (2) Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
- (3) Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
- (4) Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;

- (5) Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
- (6) Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request; and
- (7) Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

### **QUESTIONS OR COMPLAINTS**

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The participant may submit a written complain to the U.S. Department of Health and Human Service or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

### **CONTACT INFORMATION**

Davenport Community School District  
1702 N. Main St.  
Davenport, IA 52803  
(563) 445-5000

## ***DEFINITIONS***

Where the following words and phrases appear in this Plan, they shall have the respective meanings as set forth in this "Definitions" Section, unless the context clearly indicates to the contrary.

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender, unless the context clearly indicates to the contrary. The words "hereof," "herein," "hereunder" and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or Section. Section headings are included for convenience of reference and are not intended to add to, or subtract from, the terms of the Plan.

### **ACCIDENT**

Means an unforeseen or unexplained sudden bodily injury occurring by chance without intent or volition. Does not include illness or disease.

### **ACTIVELY AT WORK/ ACTIVE SERVICE**

Means a covered employee will be considered actively at work on a day which is a scheduled workday if he is performing in the customary manner all of the regular duties of his employment on a full-time basis either at his customary place of employment or at some location to which that employment requires him to travel, or if he is absent from work solely due to vacation, illness or injury.

### **ADVERSE BENEFIT DETERMINATION**

Means any of the following:

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

### **ALLOWABLE EXPENSES**

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

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would be covered by the HMO had the Participant used the services of an HMO Provider.

## **AMBULATORY SURGICAL FACILITY**

Means an institution or facility that meets all the following requirements:

- (1) It is approved by the Joint Commission on Accreditation of Healthcare Organizations or is licensed or approved by any state or local agency laws in the jurisdiction where it is located;
- (2) It is equipped and operated for the primary purpose of performing surgical procedures;
- (3) It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) and has an organized medical staff including Registered Graduate Nurses (RNs);
- (4) Provides at least two permanent operating rooms, one recovery room and equipment for emergency care;
- (5) It has an agreement with a hospital for immediate acceptance of patients who require hospital care in the case of complications or emergencies;
- (6) It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure; and
- (7) It maintains adequate medical records for each patient.

This shall not mean an office or clinic operated by one or more Physicians for the purpose of practicing medical or dental care.

## **BIRTHING CENTERS**

Means an outpatient facility meeting all the following requirements:

- (1) It complies with licensing and other legal requirements in the jurisdiction where it is located;
- (2) It is engaged primarily in providing a comprehensive birth service program to covered persons considered normal, low risk patients;
- (3) The birth services are performed by a licensed doctor of medicine (MD) or doctor of osteopathy (DO) or, at his direction, by a Certified Nurse Midwife;
- (4) It has 24-hour-a-day registered nursing services;
- (5) It maintains daily clinical records; and
- (6) It has an agreement with a hospital for immediate acceptance of patients who require hospital care in the case of complication or emergencies.

## **CALENDAR YEAR**

Means the 12-month period of time commencing on January 1 and ending on December 31 of the same year.

## **CERTIFIED NURSE MIDWIFE**

Means a fully licensed and certified registered nurse who manages the care of pregnant females and assists or performs the delivery of newborns and is entitled to use the designation of Certified Nurse Midwife.

## **CLEAN CLAIM**

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

**Filing a Clean Claim:** A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or addition information to the Plan as well.

### **CONVALESCENT HOSPITAL / EXTENDED CARE FACILITY / SKILLED NURSING FACILITY**

Means an institution or part thereof constituted and operated pursuant to law which:

- (1) Provides for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a physician or a Registered Nurse (RN). Full-time supervision means a Physician or RN is regularly on the premises at least forty (40) hours per week;
- (2) Maintains a daily medical record for each patient;
- (3) Has a written agreement or arrangement with a Physician to provide emergency care for its patients;
- (4) Qualifies as an “extended care facility” under the health insurance provided by Title XVIII of the Social Security Act, as amended; and
- (5) (for those which are not an integral part of a Hospital) has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and Convalescent Hospital.

“Convalescent Hospital” includes that part or unit of a Hospital which is similarly constituted and operated to provide room and board and 24-hour nursing service for convalescent care.

In no event, however, will a Convalescent Hospital be deemed to include a place for the aged, alcoholics, drug addicts, the blind or deaf, the mentally ill or retarded, or a place for custodial care.

### **COVERED EXPENSE**

Means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

### **COVERED PERSON**

Means any Employee or Dependent who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled in this Plan.

### **COVERED SERVICE MEMBER**

Means a member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for as serious injury or illness. Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.



## **CREDITABLE COVERAGE**

Means coverage of the individual under any of the following, excluding excepted benefits, as defined in HIPAA (Health Insurance Portability and Accountability Act):

- (1) A group health plan;
- (2) Health insurance coverage;
- (3) Part A or B of Medicare;
- (4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- (5) Chapter 55 of title 10, United States Code;
- (6) A medical care program of the Indian Health Services or of a tribal organization;
- (7) A health plan offered under chapter 89 of title 5 of the United States Code;
- (8) A State health benefits risk pool;
- (9) A public health plan; or
- (10) A health benefit plan under Section 5(e) of the Peace Corps Act.

## **CUSTODIAL CARE**

Means care or service which is designed essentially to assist a person in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, assistance in getting into or out of bed, dressing, and supervision over medication which can normally be self-administered.

## **DENTAL SERVICES**

Means care and treatment of the teeth and gums, or any services rendered by a dentist or dental surgeon.

## **DEPENDENT**

Means any of the following:

- (1) The employee's legal spouse as defined by the state in which you reside and provided such spouse is not legally separated or divorced from the employee; or
- (2) Covered employee's natural or adopted child (including a child placed with the employee for the purpose of adoption), stepchild or foster child, living in a regular parent - child relationship with the employee, a child under the employee's legal guardianship, who:
  - (a) resides in the United States; and
  - (b) is either
    - under twenty-six (26) years of age,
    - a full-time student,
    - a court-ordered decree, or
    - totally and permanently disabled, either physically or mentally, provided such disability commenced prior to age nineteen (19). Proof of incapacity must be furnished to the Plan Administrator and additional proof may be requested from time to time;
- (3) The covered employee's child who is considered to be an "Alternate Recipient" under the terms of a Qualified Medical Child Support Order that has been delivered to the Plan Administrator within thirty (30) days of the date it is issued, subject to the terms of this Plan.

## **DURABLE MEDICAL EQUIPMENT**

Means medical equipment designed for repeated use that is primarily and customarily used to serve a medical purpose and is not useful to a person in the absence of Illness or Injury. Examples of Durable Medical Equipment include but are not limited to diabetes glucometers, wheelchairs, hospital beds, and respirators, but do not include items such as air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items.

**EMERGENCY TREATMENT**

Means treatment required for accidental Injury or treatment of a sudden and unexpected Illness which has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences.

**EMPLOYEE**

Means a person who is in Active Service, regularly scheduled to work the work week of the Employer. Eligibility is based on the employment/master contract agreement. The term Employee does not include leased Employees.

**EMPLOYER**

Means Davenport Community School District #1611.

**EXHAUSTION OF COBRA CONTINUATION COVERAGE**

Means an individual's COBRA continuation coverage ceases for any reason other than either: failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

**EXPENSES INCURRED**

Means charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

**EXPERIMENTAL TREATMENT**

Means the care, procedure, treatment protocol or technology which:

- (1) Is not widely accepted as safe, effective and appropriate for the injury or sickness throughout the recognized medical profession and established medical societies in the United States; or
- (2) Is experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies; or
- (3) Drugs, tests, and technology which:
  - (a) The FDA has not approved for general use;
  - (b) Are considered experimental;
  - (c) Are for investigational use; or
  - (d) Are approved for a specific medical condition but applied to another condition.

The Plan Administrator may rely on one or more of the following in determining experimental procedures: the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, Office of Health Technology Assessment, Health Care Financing Administration, or Congressional Office of Technology Assessment. The final decision shall be at the discretion of the Plan Administrator.

**FIDUCIARY**

Means any person or organization, with respect to this Plan, who may be required to:

- (1) Exercise any discretionary authority or control with respect to management or disposition of any Plan assets;
- (2) Render any investment advice for a fee or other compensation; or
- (3) Exercise any discretionary authority or responsibility for the administration of this Plan.

### **HOME HEALTH CARE AGENCY**

Means a special care unit of a hospital or a public or private agency or organization which is primarily operated to provide home nursing care or therapeutic service. It must:

- (1) Be approved or licensed by appropriate state or local licensing authorities;
- (2) Have policies established by a professional group associated with the organization or agency, including at least one physician and one registered graduate nurse;
- (3) Maintain clinical records on each patient; and
- (4) Be approved for payment of Medicare benefits.

### **HOME HEALTH CARE PLAN**

Means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Illness or Injury would require continued confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

### **HOSPICE**

Means a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis by a Physician (life expectancy of less than 6 months). It must provide care by an inter-disciplinary team consisting of at least one physician and one registered graduate nurse, and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and any applicable state licensing requirements.

### **HOSPICE FACILITY**

Means an entity licensed, approved, or authorized to provide inpatient medical relief of pain and supportive care to terminally ill patients. Such entity must have on its premises:

- (1) Organized facilities to care for and treat terminally ill persons; and
- (2) A paid staff of medical professionals to supervise such care and treatment.

However, a Hospital or Skilled Nursing Facility shall not be considered a Hospice.

### **HOSPITAL**

Means an institution licensed as a Hospital or accredited by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association which is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons by and under the supervision of a staff of Physicians and which continuously provides 24-hour-a-day nursing services by registered nurses (RN) and is not, other than incidentally, a nursing home or a place for rest, a place for the aged, drug addicts, alcoholics, the treatment of pulmonary tuberculosis or nervous and mental disorders.

### **HOSPITAL CONFINEMENT/ADMISSION**

Means being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving emergency care in a Hospital for an Injury. Observation care or care exceeding twenty-three (23) hours will be considered an in-patient admission.

**ILLNESS**

Means a sickness or disease, including mental infirmity that requires treatment by a Physician. For purposes of determining benefits payable, Illness shall include pregnancy, childbirth or miscarriage and complication thereof, sterilization of either sex and circumcision.

**IMMEDIATE FAMILY**

Means a person's spouse, children, grandchildren, parents and siblings.

**INJURY**

Means a condition caused by accidental means of an external force which results in damages to the Covered Person's body.

**INPATIENT**

Means when a Covered Person is admitted to a Hospital as a registered bed-patient of that Hospital for confinement that is medically required. Observation care or care exceeding twenty-three (23) hours will be considered an in-patient admission.

**INTENSIVE CARE UNIT**

Means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

- (1) Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- (2) Has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- (3) Provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

**KEY EMPLOYEE**

Means a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid ten percent (10%) of all the Employees employed by the Employer within seventy-five (75) miles of the Employee's worksite.

**LATE ENROLLEE**

Means a person who enrolls under this Plan other than on:

- (1) The earliest date on which coverage can become effective under the terms of this Plan; or
- (2) A Special Enrollment Date for the person as defined by HIPAA.

**LEAVE OF ABSENCE**

Means a period of time during which the Employee does not work, but which is of stated duration after which time the Employee is expected to return to active service. The duration of any approved leave of absence is subject to the employment/master contract agreement.

**LICENSED PRACTICAL NURSE**

Means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

## **MAXIMUM AMOUNT OR MAXIMUM ALLOWABLE CHARGE**

Means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

- (1) The Usual and Customary amount;
- (2) The allowable charge specified under the terms of the Plan;
- (3) The Reasonable charge specified under the terms of the Plan;
- (4) The negotiated rate established in a contractual arrangement with a Provider; or
- (5) The actual billed charges for the covered services.

## **MEASUREMENT PERIOD**

Means the period time adopted by the Plan for Variable Hour Employees during which such Employees work hours and applicable leave are measured to determine whether such Employees are eligible for coverage. The Measurement Period for this Plan is from May 1 through April 30<sup>th</sup> of each year. Upon satisfaction of the required number of work hours as established under the Affordable Care Act (ACA), coverage will then be effective each July 1<sup>st</sup> and coverage will remain in effect for a period not to exceed twelve (12) months as long as the Variable Hour Employee remains employed by the District. At the end of the twelve (12) month coverage period, if the individual remains employed as a Variable Hour Employee and has again met the hour worked requirement, the individual may remain covered for a period of time not to exceed an additional twelve (12) months.

## **MEDICALLY NECESSARY**

Means health care services, supplies or treatment that are required to identify or treat the Illness or Injury which a Physician has diagnosed or reasonably suspects. To be medically necessary the service, supplies or treatment must be:

- (1) Consistent with the diagnosis and treatment of the patient's condition;
- (2) Consistent with professionally recognized standards of health care;
- (3) Not solely for the convenience of the patient, Physician or supplier; and
- (4) Performed in the least costly setting required by the patient's medical condition.

The fact that a Physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

## **MENTAL ILLNESS**

Means any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or others relevant State guideline or applicable sources.

## **NEWBORN**

Means an infant from the date of his/her birth until the initial hospital discharge, or until the infant is 14 days old, whichever comes later.

## **NON-OCCUPATIONAL**

A condition which does not arise out of and in the course of any employment for wage or profit and for which the person is entitled to no benefits under any Worker's Compensation law or similar legislation.

**NON-PPO NETWORK PROVIDER**

Means any health care provider who is not a contracted member of a Preferred Provider Organization under this Health Plan.

**NURSE PRACTITIONER**

Means a Registered Nurse licensed to provide basic primary health care and diagnose and treat acute illness and injuries and who is providing such services within the scope and limitation of that license.

**OUTPATIENT**

Means any expense incurred for which no hospital Room and Board charge is made (or for which a covered person is not registered as a bed-patient). Observation care or care exceeding twenty-three (23) hours will be considered an in-patient admission.

**PHYSICIAN**

Means any duly licensed Doctor of Medicine (MD), Osteopathy (DO), Physician Assistant (PA) Podiatry (DPM), Optometry (OD), Dentist (DDS or DMD), or clinical psychologist (PhD), Licensed Clinical Professional Counselor, Nurse Practitioner or Licensed Midwife providing a covered service within the scope of his license and who is required to be recognized by state law. Physicians do not include Chiropractors (DC), a person who ordinarily resides in the patient's home, or a person who is the patient's spouse, child, brother, sister, or parent, or parent of the patient's spouse.

**PHYSICIAN ASSISTANT**

Means a practitioner who is formally trained and licensed to provide diagnostic, therapeutic and preventative health care services as delegated by a Physician and who is providing such services within the scope and limitation of that license.

**PLAN**

The Davenport Community School District #1611 Employee Health Benefit Plan.

**PLAN YEAR**

Means the twelve month period of time commencing on the month and day this Plan is effective (or the annual anniversary thereof).

**POST-SERVICE CLAIM**

Means any claim for a benefit under the Plan that is not a Pre-Service Claim or an Urgent Care Claim.

**PPO NETWORK PROVIDER**

Means a contracted health care provider who is a member of a Preferred Provider Organization.

**PREFERRED PROVIDER ORGANIZATION (PPO)**

Means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the Plan Administrator or Third Party Administrator and the Preferred Provider Organization. A transplant network is also considered a Preferred Provider Organization under this Plan.

**PRE-SERVICE CLAIM**

Means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving medical care.

## **PRESCRIPTION DRUGS**

Means drugs, biologicals and solutions which are approved by the United States Food and Drug Administration and which can be dispensed only with a written prescription and are included in the United States Pharmacopoeia, the National Formulary or the New and Non-official Drugs, and insulin.

## **QUALIFIED MEDICAL CHILD SUPPORT ORDER**

Means an order must contain at least the following information:

- (1) A clause which creates or recognizes the existence of a dependent's right to receive benefits under the Plan;
- (2) The name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;
- (3) A reasonable description of the type of coverage to be provided by the Plan to each dependent;
- (4) The time period to which the order applies; and
- (5) A clause which states that the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

## **REASONABLE AND CUSTOMARY**

Means the usual charge made by a Physician or supplier of services, medicines or supplies and not exceeding the customary level of charges made by others rendering or furnishing such services, medicines or supplies within the area in which the charge is incurred and comparable in severity and nature to the illness or injury being treated. The term "area" means a county or such greater area as is necessary to obtain a representative cross-section of level of charges. Additional consideration may be given to severity, nature and complications of the illness or injury being treated.

## **REGISTERED NURSE**

Means a professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

## **ROOM AND BOARD**

Means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

## **SIGNIFICANT BREAK IN COVERAGE**

Means a period of sixty-three (63) consecutive days during all of which the participant does not have any creditable coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

## **SPECIAL ENROLLMENT PERIOD**

Subject to the terms of this Plan, if an Employee declines coverage for himself or his dependents (including a spouse) because of other health coverage, he may in the future be able to enroll himself or his dependents in this Plan, provided that he requests enrollment within thirty (30) days after his other coverage ends. In addition, if he has a new dependent as a result of marriage, birth, adoption, or placement for adoption, he may be able to enroll himself and his dependents, provided that he requests enrollment within thirty (30) days after the marriage, within sixty (6) days of the date of birth, adoption, or placement for adoption.

## **SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY**

Means the physiological and psychological addiction to a controlled drug, substance, or alcohol, purchased over-the-counter, or purchased or acquired by illegal means. Dependence on tobacco, nicotine, and caffeine are not included in this definition.

## **SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY TREATMENT FACILITY (Residential)**

Means an institution which meets all of the following requirements:

- (1) It is approved by the Joint Commission on Accreditation of Healthcare Organizations and is licensed or approved by any state or local agency laws in the jurisdiction where it is located;
- (2) It is engaged mainly in providing inpatient services for the treatment of alcoholism or drug abuse. The services include room, board and 24-hour-a-day nursing services;
- (3) The services are supervised by a Physician or by a Registered Graduate Nurse (RN);
- (4) It maintains daily clinical records; and
- (5) It must not be mainly a place of rest, a place for the aged, or a nursing or convalescent home.

## **SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY TREATMENT FACILITY (NON-RESIDENTIAL)**

Means an institution which meets all of the above requirements for an Alcohol/Drug Abuse Treatment Facility (Residential), except (2).

## **SURGERY**

Means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

If two or more surgical procedures are performed during the course of a single operation, eligible Expenses Incurred will be based on the following:

- (1) For two (2) or more procedures through the same incision: 100% of eligible Expenses Incurred will be considered for the major procedure and 50% of the eligible Expenses Incurred will be considered for the remaining procedures; and
- (2) For two (2) or more procedures not performed through the same incision: as through separate operations were performed.

## **TOTAL DISABILITY**

Means the Covered Person is completely unable, as a result of Illness or Injury, to engage in any gainful occupation for which he is reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit. A Covered Dependent will be considered to be suffering from Total Disability, if because of a non-occupational Injury or Illness, he is prevented from engaging in all normal activities of a person of like age and sex who is in good health.

## **URGENT CARE CLAIM**

Means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- (1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or,
- (2) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.



An Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as such by the Plan.

### **USUAL AND CUSTOMARY**

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

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

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

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

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

### **VARIABLE HOUR EMPLOYEE**

Means an employee who is hired as a temporary, part-time, substitute or seasonal employees and for whom average hours of service cannot reasonably be determined.

### **WAITING PERIOD**

Means the period which must pass before an employee or dependent is eligible to be covered for benefits under the terms of the Plan, except that for an individual who enrolls during a special enrollment period, any period before such special enrollment is not a waiting period.