ASP20010
Aspirus St. Luke's Employee Health Benefit Plan
HDHP Employee Medical Option

January 2026

This *certificate of coverage* may qualify as a qualified high deductible health plan within the meaning of Internal Revenue Code ("Code") section 223. This *certificate of coverage* may be used in connection with a health savings account (within the meaning of Code section 223) established by a *covered person*. *We* will not be required to establish, maintain, or contribute to a health savings account on behalf of a *covered person*. If, however, this *certificate of coverage* provides coverage for non-preventive benefits below the annual limit on *deductibles* set forth in Internal Revenue Code section 223, *you* may be ineligible to make or receive contributions to *your* health savings account ("HSA") under federal law. Please check with *your* tax advisor regarding *your* eligibility to establish or contribute to an HSA.

Customer Service	
Questions?	**Our Customer Service staff is available to answer questions about *your* coverage Monday through Friday, 7 AM – 5 PM Central Time** **When contacting us, please have *your* identification card available. If *your* questions involve a claim, we will need to know the date of service, type of service, the name of the *provider*, and the charges involved.**
Telephone Numbers:	**Monday through Friday 7 AM - 5 PM Central Time** **Toll free .... 1.866.631.5404** **Fax .... 1.763.847.4010** **Hearing impaired individuals 711**
Website:	**www.aspirushealthplan.com**
Mailing Address:	***Claims*, appeal requests, review requests, prior authorization, and written inquiries may be mailed to:** **Customer Services Department** **Aspirus Health Plan, Inc.** **P.O. Box 1890** **Southampton, PA 18966-9998**

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I. Rights of Covered Persons

The *Plan*, as defined in Section II. *Your* Employer *(Plan Administrator)*, includes one or more health *benefit* options, which may have different eligibility requirements and/or *benefits*. If a different *Summary Plan Description (SPD), SPD* option, provision or amendment applies to certain *benefit* options or classifications of individuals eligible under the *Plan*, *you* will be furnished a copy of the *SPD, SPD* option or amendment that is applicable to *you*. This *SPD* applies only to the Aspirus St. Luke's Employee Health Benefit Plan HDHP Employee Medical Option and the eligible employees enrolled for participation in this option of the *Plan*.

As a participant in the *Plan*, *you* have certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended.

ERISA provides that all *Plan* participants shall be entitled to:

Receive Information about this *Plan* and Its *Benefits*

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites and union halls, all documents governing the *Plan*, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the *Plan* annual financial report. The *Plan Administrator* is required by law to furnish *you* with a copy of the summary.

Continue Group Health Plan Coverage

- Continue health care coverage for *yourself* and/or *covered dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating *your* rights, *ERISA* imposes duties upon the people who are responsible for the operation of the employee *benefit* plan. "Fiduciaries" of the *Plan* are the people who operate *your Plan*, and have a duty to do so prudently, in *your* interest, in the interest of other *Plan* participants and *your* beneficiaries. No one, including *your* Employer, *your* union, or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a *benefit* or exercising *your* rights under *ERISA*.

Enforce *Your* Rights

If *your claim* for *benefits* under the *Plan* is denied or ignored, in whole or in part, within certain time schedules *you* have a right to:

- Know why this was done;
- Obtain copies of documents relating to this decision without charge; and
- Appeal any denial.

Under *ERISA*, there are steps *you* can take to enforce the above rights. For instance, if *you* request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 calendar days, *you* may file suit in a federal court within two years of *your* request.

In such case, the court may require the *Plan Administrator* to provide the materials and pay *you* up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If *you* have a *claim* for *benefits* under the *Plan* that is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court, within two years of the *claim* denial, (if any), or if there is no *claim* denial within two years of the date of service. In addition, if *you* disagree with the *Plan Administrator's* decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, *you* may file suit in Federal court, within two years of the date of such order. If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in Federal court, within two years of the date of such event. The court will decide who should pay court costs and legal fees. If *you* are successful, the court may order the person *you* have sued to pay costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your claim* frivolous.

Assistance with *Your* Questions

If *you* have any questions about *your Plan*, *you* should contact the *Plan Administrator*. If *you* have any questions about this statement or about *your* rights under *ERISA*, or if *you* need assistance in obtaining documents from the *Plan Administrator*, *you* should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in *your* telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. *You* may also obtain certain publications about *your* rights and responsibilities under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

II. *Your* Employer (*Plan Administrator*)

Your Employer, which also serves as the *Plan Sponsor* and the *Plan Administrator*, has established an Employee Benefit Plan (the *Plan*) to provide health care *benefits*. This *Plan* is "self-insured" which means that the *Plan Sponsor* pays the *claims* from its own assets for *covered services*. The Aspirus St. Luke's Employee Health Benefit Plan HDHP Employee Medical Option of this *Plan* is described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Plan*. *Your* Employer has contracted with *Aspirus Health Plan, Inc.* to provide *claim* processing, prior authorization, and other administrative services. However, *your* Employer is solely responsible for payment of *your* eligible *claims*.

The *Plan Administrator* in its sole discretion shall, to the fullest extent permitted by law, determine appropriate courses of action in light of the reason and purpose for which this *Plan* is established and maintained. The *Plan Administrator* has, to the fullest extent permitted by law, the exclusive and final discretionary authority to revise the method of accounting for the *Plan*, establish rules, and prescribe any forms required for administration of the *Plan*. All determinations and decisions made by or on behalf of the *Plan Administrator* will be final and binding on the *Plan*, all persons covered by the *Plan*, all persons or entities requesting payment or a *claim* for *benefits* under the *Plan* and all interested parties, to the fullest extent permitted by law. The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive and final binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, to the fullest extent permitted by law, except to the extent the *Plan Administrator* has expressly delegated to other individuals or entities one or more fiduciary responsibilities with respect to the *Plan*.

The *Plan Sponsor*, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the *Plan*. This includes, but is not limited to, changes to *contributions,* copayments*, deductibles, coinsurance, out-of-pocket limits, benefits* payable and any other terms or conditions of the *Plan*. The decision to change the *Plan* may be due to changes in federal laws governing welfare *benefit*s, or for any other reason. The *Plan* may be changed to transfer the *Plan's* liabilities to another plan or split this *Plan* into two or more parts.

The *Plan Administrator* has the power to delegate specific duties and responsibilities. The *Plan Administrator* may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated, shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

III. Aspirus Health Plan, Inc. (*Aspirus Health Plan, TPA*)

Aspirus Health Plan, Inc., as an external administrator referred to as a *third party administrator (TPA)*, provides certain administrative services, including *claim* processing services, subrogation, utilization management and complaint resolution assistance.

IV. Introduction to *Your* Coverage

A. Summary Plan Description (SPD)

This *Summary Plan Description (SPD)* is *your* description of the Aspirus St. Luke's Employee Health Benefit Plan HDHP Employee Medical Option of the *Plan Sponsor's Plan*. **Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give *you* incomplete information regarding *your* rights and responsibilities under the *Plan*.** The *SPD* describes the *Plan's benefits* and limitations for *your* health care coverage. Included in this *SPD* is a *Benefit* Schedule that states the amount payable for the *covered services*. *Benefits* are not covered for excluded services, and exclusions include, but are not limited to, *health care services* that are not *medically necessary* as determined by the *Plan Administrator*. Be sure to review the list of exclusions as well as the *Benefit* Schedule. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. *Benefits* are not available for *medically necessary* services, unless such services are also *covered services*. ***Benefits* are limited to the most cost effective and *medically necessary* alternative**. The *Plan Administrator* has, to the fullest extent permitted by law, the sole, final, and exclusive discretion to determine *benefits* available under the *Plan*.

Italicized words used in this *SPD* have special meanings and are defined at the back of this *SPD*. *You* should keep *your SPD* in a safe place for *your* future reference. Amendments that are included with this *SPD* or adopted by the *Plan Sponsor* are fully made a part of this *SPD*.

This *SPD* is intended to comply with the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended. This *Plan* is maintained exclusively for *you*. *Your* rights under the *Plan* are legally enforceable.

B. Administrative Services Agreement

The signed Health Services Network Access and Administration Agreement between *your* Employer and the *TPA* constitutes the entire agreement between *your* Employer and the *TPA*. A version of the Health Services Network Access and Administration Agreement is available for inspection from *your* Employer.

C. Identification Cards

The *TPA* issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, *claims* for *benefits* under the *Plan* or bills and/or invoices for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive *health care services*.

D. PPO Medical Option

This employee medical option is a Preferred Provider Organization (PPO) medical option under the *Plan*. A PPO medical option allows *you* to receive *health care services* from the *provider you* select without requiring a *referral*.

E. *Provider* Directory

You may find *participating providers* by going to our website at https://p1.aspirushealthplan.com/find-a-doctor and signing in to your account. In the section of the web page entitled **FIND A DOCTOR**, there are links with the names of the *provider* networks you have access to under this *SPD*. Clicking on a link will take you to the directory of *participating providers* in that *provider* network. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes and Aspirus Health Plan, Inc. does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that the *provider you* choose is a *participating provider* by calling Aspirus Health Plan, Inc. Customer Service at the telephone number listed on the inside cover of this *SPD*. If you call Customer Service, Aspirus Health Plan, Inc. will respond to *you* as soon as practicable but in no case later than 1 business day after *your* call is received, through a written electronic communication or, at *your* request, a hard copy communication. *Provider* directories are available to *you* upon request.

If either:

1. *You* received through a telephone call to Aspirus Health Plan, Inc. Customer Service, or through an Internet-based provider directory made available by Aspirus Health Plan, Inc., information confirming that a *provider* was a *participating provider* with respect to furnishing certain *health care services* but the *provider* which furnished the *health care services* after *you* received such information was a *non-participating provider*; or
2. We did not make available an Internet-based provider directory and *you* requested before *you* received certain *health care services* through a telephone call to Aspirus Health Plan, Inc. Customer Service information on whether the

provider was a *participating provider* with respect to furnishing such *health care services* and was informed by Customer Service that the *provider* was a *participating provider*;

Then the Aspirus Health Plan, Inc.,

1. Shall not impose on *you* a cost-sharing amount (e.g. a *deductible* or copayment) for such *health care services* furnished by the *non-participating provider* that is greater than the cost-sharing amount that would apply had such *health care services* been furnished by a *participating provider*; and
2. Shall apply the out-of-pocket maximum that would apply if such *health care services* were furnished by a *participating provider*.

F. For Non-Emergency Services Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs *health care services* for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers*, will be covered at the *participating provider* level of *benefits* as shown in the "*Benefit* Schedule."

If a *non-participating provider* arranges or performs *health care services* for *you* at a *participating provider* facility, all related eligible non-facility charges from any *non-participating providers* will be covered at the *non-participating provider* level of *benefits* as described in the "*Benefit* Schedule." *You* will be responsible for any charges that may exceed the *usual and customary amount.* Regardless, radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but provided at a *participating provider* facility, will be subject to the applicable *participating provider* level of *benefits* as shown in the benefit schedule.

G. Case Management

In cases where *your* condition is expected to be or is of a serious nature, Aspirus Health Plan, Inc. may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the *Plan*.

Under certain conditions, the *Plan Administrator* will consider other care, services, supplies, reimbursement of expenses, or payments of *your* serious *sickness* or *injury* that would not normally be covered or would only be partially covered. The *Plan Administrator* and *your provider* will determine whether any medical care, treatments, services, supplies, reimbursement of expenses or payments will be covered. Such care, treatment, services, supplies, reimbursable expenses, or payments provided will not be considered as setting any precedent or creating any future liability, with respect to *you*, or any other *covered person*.

H. Conflict with Existing Law

If any provision of this *SPD* conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

I. Privacy

This *Plan* is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rules, the *Plan* and the *TPA* acting on the *Plan's* behalf, maintains, uses, or discloses *your* Protected Health Information for purposes such as *claims* processing, utilization review, quality assessment, case management, and otherwise as necessary to administer the *Plan*. *You* can obtain a copy of the *Plan's* Notice of Privacy Practices (which summarizes the *Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how the *Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Plan Administrator*.

J. Processing Delays, Fraud, Misrepresentation, Rescission and Right to Audit

If routine processing delays occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under the *Plan* for which *you* are not eligible under the *Plan*. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination except where required by law. It is *your* responsibility to confirm the accuracy of statements made by the *Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and other *plan* documents. *Your* coverage may not be retroactively terminated unless *you* request it or *you* (or someone acting on *your* behalf) falsifies information, submits fraudulent, altered or duplicate billings, allows another person not covered under the *Plan* to use *your* coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*. Notwithstanding, *you* may be terminated, including being retroactively terminated, due to a failure to timely pay required *contributions*.

For the purpose of managing *your* overall health status, health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; for *claim* processing purposes; and for payment purposes, by enrolling in coverage *you* authorize: (1) the *Plan* to disclose *your* health information with health care *providers* and subcontractors of health care *providers* or of the *Plan* that provide services; and (2) such health care *providers* and subcontractors to disclose *your* health information to each other and to the *Plan*.

Determination of *your* coverage will be made at the time a *claim* is reviewed. In addition, the *Plan Administrator* may require *you* to furnish proof of *your* eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *contributions* and the coverage provided under the *Plan*. If the *Plan Administrator* determines that, after reasonable requests, *you* have failed to provide adequate records or sufficient proof of *your* eligibility status, the *Plan Administrator* may, in its sole discretion, rescind or terminate *your* coverage to the extent permitted by law.

K. Limited Access to Participating Providers

In the event that the *Plan Administrator* determines *you* are receiving *health care services*, including *prescription drugs* in a quantity or manner that might be harmful to *your* health, the *Plan Administrator* will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician, hospital* and pharmacy to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, the *Plan Administrator* will choose for *you.*

Failure to receive *health care services* through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers*, *you* must obtain a written *referral* from *your* selected participating *physician*.

L. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your benefits* and coverage under this *SPD,* including coverage examples, that is prepared in a uniform style. If there is a conflict between this *SPD* and the SBC, this *SPD* governs and the *TPA* will administer *your* coverage in accordance with this *SPD*.

M. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *SPD* does not guarantee that medical equipment, supplies or *prescription drugs* will continue to be covered, even if the equipment, supply or drug was covered previously in a *calendar year*.

N. Routine Patient Costs Associated with Clinical Trials

The *Plan* covers *routine patient costs* associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of *routine patient costs* for items and *health care services* furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial.*

If one or more *participating providers* are participating in a *clinical trial*, the *Plan* will cover *routine patient costs* only if *you* participate in the *clinical trial* through a *participating provider* if the *provider* will accept *you* in the *clinical trial.* This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. However, the *Plan* will not cover *routine patient costs* if *you* are in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider benefits*.

O. Essential Health Benefits Benchmark

Employer acknowledges and agrees that, to the extent required by the *Affordable Care Act*, the *essential health benefits* of the Wisconsin benchmark apply to the *Plan*.

P. Balance Billing

1. If you receive *emergency services* (for which *benefits* are provided under this *SPD*) because of an *emergency medical condition* with respect to a visit at an *emergency department of a hospital* or an *independent freestanding emergency department*, which is a *non-participating provider,* then such *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *emergency services* which is more than the *deductible* and *coinsurance* requirements for such services under this *SPD*.

2. If a *non-participating provider* furnishes *health care services* other than *emergency services* (for which *benefits* are provided under this *SPD*) to *you* at a *hospital* or ambulatory surgical center, which is a *participating provider*, then:

a. The *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *health care services* furnished by such *non-participating provider* with respect to a visit at the *hospital* or ambulatory surgical center which is more than the *deductible* and *coinsurance* requirements for such services under this *SPD*; unless;

b. The *health care services* are not *ancillary services* and the *non-participating provider* satisfies the notice and consent criteria in paragraph c.

c. The *non-participating provider* provides to the *covered person*:

   i. A written notice in paper or electronic form, as selected by *you*, that contains the following information:

   - A statement that the *provider* is a *non-participating provider*;
   - The good faith estimated amount that such *non-participating provider* may charge *you* for the *health care services* involved (and any other related *health care services* reasonably expected to be furnished by the *non-participating provider*), including notification that the provision of the estimate or consent does not constitute a contract with respect to the estimated charges or a contract that binds the *covered person* to be treated by the *hospital*, ambulatory surgical center, or *non-participating provider*;
   - A statement that prior authorization or other care management limitations may be required in advance of receiving such *health care services* at the *hospital* or ambulatory surgical center;
   - A statement that consent to receive such *health care services* from such *non-participating provider* is optional and that the *covered person* may instead seek care from an available *participating provider* and that the cost-sharing responsibility of the *covered person* would not exceed the responsibility that would apply with respect to such *health care services* furnished by a *participating provider*.

   ii. A consent form that must be signed by the *covered persons* before such *health care services* are furnished and that:

   - Acknowledges that the *covered person* has been:
     - Provided with the written notice described in paragraph i. of this subsection, in the form selected by the *covered person*; and
     - Informed that the payment of such charge by the *covered person* might not accrue toward meeting any limitation that *your* coverage places on cost sharing, including an explanation that such payment might not apply to an in-network *deductible* or *out-of-pocket maximum* applied under *your* coverage;
   - States that by signing the consent form, the *covered person* agrees to be treated by the *non-participating provider* and understands the *covered person* may be balance billed and subject to cost sharing requirements that apply to *health care services* furnished by the *non-participating provider*; and
   - Documents the time and date on which the *covered person* received the written notice described in paragraph i. of this subsection and the time and date on which the *covered person* signed the consent form to be furnished such *health care services* by such *non-participating provider*.

The No Surprises Act prohibits balance billing in most circumstances. If you have questions regarding what constitutes a "Balance" bill, please contact Customer Service at 1-866-631-4611 (toll free) or visit our website at www.aspirushealthplan.com.

Q. Transition of Care and Continuity of Care

Eligibility for transition of care *benefits* at time of enrollment

You are eligible for transition of care *benefits* if:

You are, at the time of enrollment:

1. a *continuing care patient*, which means *you* are, with respect to a *provider*:
   a. Undergoing a course of treatment for a *serious and complex condition* from the *provider*;
   b. Undergoing a course of institutional or inpatient care from the *provider*;
   c. Scheduled to undergo non-elective surgery from the *provider*;
   d. Either in the second or third trimester of pregnancy and undergoing a course of treatment for the pregnancy from the *provider*; or
   e. Terminally ill and receiving treatment for such illness from the *provider*;
2. Receiving care from this *provider,* and the *provider* is the only culturally appropriate *provider* within 30 miles or 30 minutes travel from *your* place of residence; or
3. Unable to speak English, and Aspirus Health Plan, Inc. does not have a *provider* in its *participating provider* network

that can provide care to *you* either directly or through an interpreter.

Your provider must request transition of care *benefits* at the time of enrollment or no later than 30 days after the *effective date* for *your* coverage.

Eligibility for continuity of care *benefits*

You are eligible for continuity of care *benefits* if:

1. *You* are either 1(a), 1(b), or 1(c), as described above in the **Eligibility for transition of care *benefits* at time of enrollment** section above; and
2. Either *your* continuity of care *provider's* agreement has terminated or the *benefits* for which *you* need continuing care with respect to such *provider* terminated because of a change in the terms of the *provider*'s agreement.

Your provider must request continuity of care *benefits* within 30 days of the applicable termination date in section 2 above.

How to request transition of care or continuity of care *benefits*

1. *Your provider* must either:
   a. Complete the applicable form:
      i. Continuity of Care: https://aspirushealthplan.com/webdocs/60024-AHP-Continuity-of-Care-Prior-Authorization-Form_SE.pdf; or
      ii. Transition of Care: https://www.aspirushealthplan.com/webdocs/AHP-046-Transition-of-Care-Request-Form.pdf; or
   b. contact Customer Service at the telephone number listed on the inside cover of this *SPD*.
2. *Your provider* must submit a complete form that includes the *provider's* signature and all required documentation.
3. *You* must request that *your provider* submit the form within the required time frame. Requests received after the required time frame will be denied, unless a longer time frame is required by law or we determine that extraordinary circumstances prevented timely submission.

Transition of care and continuity of care *benefits*

1. If the request is approved, *you* will receive:
   a. In the case of transition of care, *participating provider benefits* provided under this *SPD*, with respect to the course of treatment furnished by *your* transition of care *provider* relating to *your* status as a *continuing care patient*.
   b. In the case of continuity of care, the *participating provider benefits* provided under this *SPD*, under the same terms and conditions as would have applied and with respect to such *health care services* as would have been covered under this *SPD* had *you* not become eligible for continuity of care *benefits*, with respect to the course of treatment furnished by *your* continuity of care *provider* relating to *your* status as a *continuing care patient*.
2. In the case of transition of care, if *you* choose to continue receiving care from the transition of care *provider* beyond the approved time frame, this *SPD*'s *non-participating provider* coverage provisions will apply after the expiration of the approved time frame, including any applicable prior authorization requirements.
3. *You* have the right to receive an explanation of our decision on whether to approve your request for transition of care or continuity of care *benefits*, including the reason for denial if *your* request was not approved.

Duration of the continuity of care and transition of care *benefits*

Transition of care *benefits* end on the earlier of the first day following the 90-day period beginning on the effective date of coverage under this *SPD* or the date upon which *you* have recovered from *your serious and complex condition*, if applicable.

Continuity of care *benefits* end on the earlier of the first day following the 90-day period beginning on the applicable termination date or the date upon which *you* have recovered from *your serious and complex condition*, if applicable.

However:

1. If *you* were either in the second or third trimester of pregnancy when *you* became eligible for transition or continuity of care *benefits*, *participating provider benefits* end after the twelve-week post-partum period.
2. If *your* continuity of care *provider's* agreement was terminated and the termination was not for cause, continuity of care *benefits* continue through the rest of *your* life if a *physician*, advanced practice registered nurse, or physician assistant certifies that *you* have an expected lifetime of 180 days or less.

R. *Benefit* Exception Requests

Except as provided in Section **IV.E. For Non-*Emergency Services* Received in a *Participating Provider* Facility from a *Non-Participating Provider*** and **Section VI.C. Ambulance Services**, if a non-*emergency* situation arises that makes it *medically necessary* for *you* to obtain *health care services* from a *non-participating provider*, *you* may request a *benefit* exception from the *Plan*. The *Plan* has full discretionary authority to allow coverage of *health care services* from a *non-participating provider* at the *participating provider* level of *benefits*. The *Plan* will only approve a *benefit* exception for *health care services* provided by a *non-participating provider* when those *health care services* are not reasonably available from a *participating provider* and are *medically necessary* to treat *your* illness or *injury*.

A *benefit* exception request must be submitted in writing by *your participating provider* and must be approved in writing by the *Plan* prior to *your* receipt of the *health care services*. If *you* receive written approval from the *Plan* for *your benefit* exception request, *you* will not be responsible for billed charges above the *usual and customary amount* for such services.

If *your benefit* exception request is denied *benefits* will be payable at the *non-participating provider benefit* level and *you* will be responsible for any billed charges above the *usual and customary amount.*

S. Participating Employers

The following are participating employers of the *Plan*:

Aspirus St. Luke's Hospital of Duluth

Aspirus Lake View

V. Eligibility, Enrollment, and *Effective Date*

A. Eligibility

You are eligible to enroll for coverage if *you* are:

1. Classified by the *Plan Sponsor* as a part-time or full-time employee regularly scheduled to work a minimum of 24 hours per week; or
2. An eligible dependent of the employee. An employee must enroll for coverage in order to enroll eligible dependents.

Eligible dependents include a *covered employee's*:

1. Lawful spouse whose marriage to the *covered employee* is valid under applicable state law.
2. Children, from birth through the end of the month in which the child reaches age 26, including a:
   a. Natural child of a *covered employee* from birth;
   b. Legally adopted children or children placed with the *covered employee* for legal adoption (date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support).
   c. Children under age 26 for whom the *covered employee* or the *covered employee's* covered lawful spouse has been appointed legal guardian by a court of law prior to age 18;
   d. *Stepchild* of the *covered employee*;
   e. Child covered under a valid Qualified Medical Child Support Order (QMCSO), as defined under section 609 of the Employee Retirement Income Security Act (*ERISA*) and its implementing regulations, which is enforceable against an eligible employee or a *covered employee*. An eligible employee or a *covered employee* may contact the *Plan Administrator* for free assistance in obtaining information regarding the procedures governing QMCSO determinations. The *Plan Administrator* is responsible for determining whether or not a medical child support order is a valid QMCSO.
3. Child of the *covered employee* who is a *full-time student returning from military duty.* Children who are age 27 or more when discharged from the military and who are enrolled as students in regular full-time attendance at an accredited secondary or post-secondary educational institution as recognized by the U.S. Secretary of Education, which is an accredited high school, university, four-year college, community college, technical school, or vocational school. In order to qualify as an eligible dependent under this provision:
   a. The student must carry the required number of credits per quarter/semester to qualify as a full-time student, as defined by the educational institution; and
   b. The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.

   Notwithstanding the provisions set forth above, a *covered dependent* shall be able to continue coverage from the date of a *medically necessary* leave of absence or change in student enrollment until the earliest of the date that is: 1) one year after the first day of such leave of absence or change in student enrollment; 2) the date on which such leave of absence or change in student enrollment is no longer medically necessary; or 3) the date on which coverage would otherwise end under the terms of the *Plan* (e.g., upon attaining the maximum age) if the *covered dependent*:
   a. is a full-time student in a post-secondary accredited school and enrolled in the *Plan* on the day before a medically necessary leave of absence or change in student enrollment starts;
   b. takes the leave of absence or makes a change to student enrollment as a result of a serious illness or injury that the attending physician certifies is medically necessary; and
   c. loses full-time student status as a result of the *medically necessary* leave of absence or change in student enrollment.
4. For dependent children who are covered under this *SPD* and disabled prior to the date the dependent child reaches age 26, application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 31 calendar days after the dependent child reaches age 26. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* may request proof again at any time during the two-year period following the child's attainment of the limiting age but not more frequently than annually after such two-year period. A dependent child may be eligible for coverage if coverage has not otherwise terminated by the *Plan* and if the dependent child meets all of the following criteria:
   a. Became disabled before age 26;

b. Was a *covered dependent* enrolled with the *Plan* prior to reaching age 26;
c. Is incapable of self-sustaining employment because of a *physical disability*, developmental disability, mental illness, or mental health disorder; and
d. Is dependent on the *covered employee* for a majority of financial support and maintenance.

The disabled dependent child shall be eligible for coverage as long as the dependent child is and continues to be disabled and dependent on the *covered employee*, unless coverage otherwise terminates under the *Plan.*

Note: Coverage will be rescinded or terminated in the event of fraud, intentional misrepresentation of material fact (including a misleading omission of material fact) or failure to pay, when due, any required premium.

B. Enrollment and *Effective Date*

New Enrollment. The eligible employee must make an application to enroll, including any eligible dependents that the eligible employee wishes to enroll, and pay/reimburse any required *contributions* to the Employer, within 31 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first day of the month coinciding with or immediately following completion of a 30-day *waiting period*. The waiting period will be credited for any time worked as temporary or seasonal employee; or as a permanent employee working less than 24 hours per week.

For eligible employees of an acquired entity, coverage under the *Plan* shall be effective on the first day of the calendar month following acquisition. If an acquisition occurs on the first day of the calendar month, coverage shall be effective on the date of acquisition.

Annual Enrollment. Subject to all eligibility and enrollment provisions, the employee may enroll, and may include eligible dependents; or a *covered employee* may add eligible dependents during the Employer's annual enrollment period. Coverage will be effective on the date indicated during the annual enrollment.

Rehire. If an employee's single or family coverage under the *Plan* terminates because of ineligibility due to temporary layoff, seasonal layoff, leave of absence or temporary reduction in work hours and the employee becomes eligible for coverage under the *Plan* at a later date, the employee must meet all requirements for eligibility and will be effective on the first day of the month following the date of rehire. If an eligible employee or eligible dependent does not enroll for coverage within this period and is not otherwise eligible for a special enrollment period, as outlined below, the eligible employee must wait to enroll for coverage during the next annual enrollment period.

Revocation of Family Coverage due to Spouse or Dependent's Enrollment in a *Qualified Health Plan*. The *covered employee* may revoke their election of family group health plan coverage if all of the following conditions are met:

1. One or more related individuals (e.g. spouse or dependent) is eligible for a special enrollment period to enroll in a *Qualified Health Plan* through a Health Insurance Marketplace (pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance) or one or more already covered related individuals seeks to enroll in a *Qualified Health Plan* through a Health Insurance Marketplace during the Health Insurance Marketplace*'s* annual open enrollment period; and
2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual(s) in a *Qualified Health Plan* through a Health Insurance Marketplace for new coverage that is effective beginning no later than the date immediately following the last day of the original coverage that is revoked; and
3. If the employee does not enroll in a *Qualified Health Plan* through a Health Insurance Marketplace as otherwise permitted herein, the employee can only revoke coverage for the individual(s) enrolling in the Health Insurance Marketplace.

Special Enrollment Period for Employees and Dependents. If *you* are an eligible employee or an eligible dependent of an eligible employee but not enrolled for coverage under this *Plan*, *you* may enroll for coverage under the terms of this *Plan* if all of the following conditions are met:

1. *You* were covered under a group health plan, covered under the BadgerCare Plus program, or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. The eligible employee stated in writing at the time of initial eligibility that coverage under a group health plan, the BadgerCare Plus program, or health insurance coverage was the reason for declining enrollment, but only if the Employer required a statement at such time and provided the employee with notice of the requirement and the consequences of such requirement at the time;

3. *Your* coverage described in paragraph 1 above was:
   a. Terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
   b. Terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), or for coverage that is not COBRA continuation coverage, or employer *contributions* toward such coverage were terminated; or
   c. Terminated as a result of loss of eligibility for the BadgerCare Plus program; and
4. The eligible employee requested such enrollment not later than 31 calendar days after the date of the event described in paragraphs 3.a or 3.b above, or not later than 60 calendar days after the date of loss of eligibility for the BadgerCare Plus program described in paragraph 3.c above.

   Coverage will be effective on the date of the event described in paragraphs 3.a - c above, provided the *Plan* receives the application for coverage as required.

Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and
2. The employee is eligible for coverage under this *Plan*; and
3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This *Plan* shall provide a dependent special enrollment period during which the person may be enrolled under this *Plan* as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this *Plan*. In the case of marriage, the employee, the spouse and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and
4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage will be effective on the date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in paragraph 3 above.

Birth of a child. Coverage is provided for a newborn biological child who meets the definition of eligible dependent from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. If coverage is needed to continue after the 60 days, *you* must add the child.

If a *covered employee* has family coverage, coverage is provided for a newborn child who meets the definition of eligible dependent from the moment of that child's birth. You should notify us of the child's birth.

If the *covered employee* has single coverage or limited family coverage, coverage is provided for a newborn natural child who meets the definition of eligible dependent from the moment of that child's birth and shall be for the initial 60 days of that child's life. If the *covered employee* elects not to change to limited family coverage or family coverage, coverage for the newborn natural child shall terminate retroactively back to that child's date of birth.

To add a newborn natural child, *you* must submit an enrollment form to apply for coverage within the first 60 days of the date of birth of the child. The effective date for such coverage will be the date of that child's birth. If the *covered employee* fails to apply within that 60-day period, his/her newborn natural child's coverage shall terminate retroactively back to the child's date of birth and the newborn may not be added until the next annual enrollment period.

Note: Other dependents (such as siblings of a newborn child) are entitled to special enrollment rights upon the birth of a child.

Newly Adopted Child Enrollment. Coverage is provided for children newly adopted or placed for adoption, who were adopted or placed for adoption while the *covered employee* is covered under this *SPD*, and who are otherwise eligible for coverage. *We* must receive an application to add the child within 60 days of the date of adoption or placement for adoption. If *you* submit an application more than 60 calendar days after the date of adoption, or placement for adoption, the adopted child may not be added until the next annual enrollment period.

If a *covered person* has family coverage, coverage is provided for the adopted child who meets the definition of eligible dependent from the moment of that child's date of adoption or placement for adoption.

If the *covered employee* has single coverage or limited family coverage and wishes to change to limited family coverage or family coverage because of his/her adoption of a child or a child placed for adoption, we must receive an enrollment form listing the child(ren) the *covered employee* wants to enroll within 60 days of the date of the adoption or placement for adoption. The effective date for such limited family or family coverage will be one of the following: (a) the date a court makes a final order granting adoption of the child by the *covered employee*; or (b) the date that the child is placed for adoption with the *covered employee*.

If the adoption of a child who is placed for adoption with the *covered person* is not finalized, the child's coverage will terminate when the child's placement for adoption with the *covered person* terminates.

Note: Other dependents (such as siblings of an adopted child) are entitled to special enrollment rights upon the adoption of a child.

Legal Guardianship. Coverage is provided for children under age 26 for whom the *covered employee* or the *covered employee's* covered lawful spouse has been appointed legal guardian by a court of law prior to age 18; *We* must receive an application to add the child within 60 days of the date that the *covered employee* or the *covered employee's* spouse was named legal guardian. If *you* submit an application more than 60 calendar days after the date that the *covered employee* or the *covered employee's* spouse was named legal guardian, the child may not be added until the next annual enrollment period.

If a *covered person* has family coverage, coverage is provided for the child for whom the *covered employee* or *covered employee's* spouse has been named legal guardian, and who meets the definition of eligible dependent, from the moment that the *covered employee* or the *covered employee's* spouse is named legal guardian.

If the *covered employee* has single coverage or limited family coverage and wishes to change to limited family coverage or family coverage because the *covered employee* or the spouse of the *covered employee* is named legal guardian of a child, *we* must receive an enrollment form listing the child(ren) the *covered employee* wants to enroll within 60 days of the date that the *covered employee* or *covered employee's* spouse was named legal guardian. The effective date for such limited family or family coverage will be the date that the *covered employee* or *covered employee's* spouse is named legal guardian.

The child's coverage will terminate when legal guardianship is terminated, or such earlier date as applies under the "Ending *Your* Coverage" provision of this *SPD*.

Note: Other dependent children are entitled to special enrollment rights associated with legal guardianship.

Qualified Medical Child Support Order

The *Plan* will provide coverage in accordance with a Qualified Medical Child Support Order (QMCSO), National Medical Support Notice (NMSN), or Child Support Order ("Child Support Order") pursuant to the applicable requirements under § 609 of the Employee Retirement Income Security Act (ERISA) and § 1908A of the Social Security Act and any other applicable laws. It is the employer's responsibility to determine whether a medical child support order is qualified.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the employer will follow its established procedures for determining whether the medical child support order is qualified. The employer will provide the *Plan* with notice of a Child Support Order and a copy of the order along with an application for coverage within the greater of 31 days of issuance of the order or the time in which the employer provides notice of its determination to the persons specified in the order.

Where a Child Support Order requires coverage to be provided under the *Plan* and an eligible employee's child is not already a *covered dependent*, then such child will be provided a special enrollment period. If the eligible employee whose child is the subject of the Child Support Order is not enrolled at the time enrollment for the child is requested, then the eligible employee must also enroll for coverage under the *Plan* during the special enrollment period. The effective date of coverage will either be the date the Child Support Order is issued or pursuant to another coverage date set forth in the Child Support Order.

Where a Child Support Order requires coverage to be provided for under the *Plan* for a *covered employee's child* who is already a *covered dependent*, such child will continue to be provided coverage under the *Plan* pursuant to the terms of the Child Support Order.

Special Enrollment Period for Medicaid, including BadgerCare Plus and Children's Health Insurance Program (CHIP) Participants. If an eligible employee and/or the eligible employee's eligible dependents are covered under a state Medicaid Plan, including BadgerCare Plus, or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or eligible dependents. Such request shall be submitted to the *Plan* not later than 60 calendar days after the eligible employee's and/or the eligible employee's dependent's coverage ends under such state plans.

If an eligible employee and/or the eligible employee's eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the Employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or such eligible dependents. The eligible employee shall request such enrollment in the *Plan* no later than 60 calendar days after the date the employee and/or the eligible employee's eligible dependents are determined to be eligible for coverage under such state plans.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in a Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 8-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer's plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer's plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

VI. Benefit Schedule

You are required to pay any *deductible* and *coinsurance* amount. *Benefits* listed in this Schedule are according to what the *Plan* pays. *Benefits* are limited to the most cost effective and *medically necessary* alternative. Any amount of *coinsurance you* must pay to the *provider* is based on 100% of *eligible charges* less the percentage covered by the *Plan*. *Plan* payment begins after *you* have satisfied any applicable *deductible* and *coinsurance*.

Discounts negotiated by the *TPA* with *providers* may affect *your coinsurance* amount. This *Plan* may pay higher *benefits* if *you* choose a *participating provider*. If *you* use a *non-participating provider*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*, when applicable.

A. Prior Authorization

Approval of a prior authorization request by the *Plan Administrator* does not guarantee payment for services. Whether or not we grant prior authorization, payment for services will depend on whether, at the time the services are performed, *you* are a *covered person* who is *eligible* for and enrolled under this *SPD*, the services are *medically necessary*, are *covered services*, *you have* provided the appropriate information for those services, and *you* have met all other terms of the *SPD*. Please read the entire *SPD* to determine which other provisions might also affect *benefits*.

Prior Authorization Recommendation: It is recommended that *you* or *your provider* request in advance that certain *health care services* be authorized as *medically necessary* in advance by the *Plan Administrator*. When a *participating provider* renders services, the *provider* will obtain authorization in advance from the *Plan* for *you* by following the procedures explained in this section of this *SPD*. It is *your* responsibility to obtain prior authorization from the *Plan* and to follow the procedures in this section of this *SPD* when *you* receive services from *non-participating providers*. *You* should follow the procedures for prior authorization appeals as shown in "*Claim* Appeals and Prior Authorization Appeals Processes."

The prior authorization process is recommended for a variety of services including, but not limited to, those listed below, and others that are listed in our "Prior Authorization List": If *you* have questions about prior authorization, please contact Customer Service.

Prior authorization is recommended before the following medical services are received:

1. All non-*emergency* inpatient admissions including *skilled nursing facility*, rehabilitation, *hospital*, etc.;
2. *Transplant services*;
3. Drugs or procedures that could be construed to be *cosmetic*;
4. Home health care or hospice;
5. Non-*emergency* transportation
6. Outpatient surgeries;
7. Physical therapy, occupational therapy, speech therapy and other outpatient therapies;
8. Pain therapy;
9. *Reconstructive* surgery;
10. *Bariatric surgery*;
11. Genetic testing; and
12. Durable medical equipment (DME) or prosthesis that might exceed $500.

You can access the current list by logging in to *your* member home page at www.aspirushealthplan.com.

Prior authorization is required for certain *prescription drugs* before *you* fill *your* prescription at a pharmacy. The list of *prescription drugs* which require prior authorization may be found at www.aspirushealthplan.com/insurance/priorauthorization.

Should Wisconsin, Minnesota, Michigan, Pennsylvania, or the Wausau, Minneapolis/St. Paul, or Philadelphia metropolitan area(s) be declared a disaster area or subject to a pandemic alert, or in the event of a cyber-attack, we may suspend prior authorization and other services as may be determined by the *Plan Administrator*.

Prior Authorization Procedure for Non-Acute Care Pre-Service Requests

Filing Procedure for Non-Acute Care Pre-Service Requests. To request prior authorization, a phone call must be made to Customer Service at least seven business days before the date services requiring prior authorization are provided and all essential data elements must be supplied. An expedited review is available if *your* attending *provider* believes *your* medical condition warrants it. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Requests" for the list of essential data elements that are required to file a pre-service request. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed, and *you* will be notified within five calendar days. Please note that the time periods for making a determination decision begin when Customer Service receives a prior authorization request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests prior authorization on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative.

Initial *Benefit* Determination Decision of Non-Acute Care Pre-Service Requests. *You* and *your* attending *provider* will be notified of the *TPA's* decision within 15 calendar days (or a shorter time period as required by applicable law) after receipt of a prior authorization request submitted in accordance with the *Plan's* filing procedures, provided the *TPA* has all necessary information needed to make a decision.

If the *TPA* does not have all information it needs to make a decision, or in other circumstanced permitted by law, then it may extend the time period for making the decision by 15 calendar days (or a shorter time period as required by applicable law). The *TPA* will notify *you* of the extension and the time period to provide the requested information. If *you* do not provide the requested information within the time period specified, *your* request will be denied.

The decision may be communicated to *your* attending *provider* by telephone.

If *your* prior authorization request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- Information sufficient to identify the request involved and any information required by law; The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the request acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals and Prior Authorization Appeals Processes" for details on requesting an appeal or external review for *claims* appeals.

Expedited Prior Authorization Procedure for Acute Care Pre-Service Requests

Acute care services are services needed when a delay in treatment could seriously jeopardize *your* life or health or the ability to regain maximum function or, in the opinion of *your* attending *provider*, could cause severe pain. An expedited decision will be made for requests for services for which prior authorization is recommended if *your* attending *provider* believes *your* medical condition warrants acute care services.

Filing Procedure for Acute Care Pre-Service Requests. To request expedited prior authorization a phone call must be made to Customer Service before the date services for which prior authorization is recommended are provided and all essential data elements must be supplied. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service Requests" for the list of essential data elements that are required to file a pre-service request. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed, and *you* will be notified within 24 hours. Please note that the time periods for making an expedited decision begin when Customer Service receives a prior authorization request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests prior authorization on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated prior authorization appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining prior authorization appeals.

Expedited Initial *Benefit* Decision of Acute Care Pre-Service Requests. An expedited decision will be provided by the *TPA* to *you* and *your* attending *provider* as quickly as *your* medical condition requires, but no later than 72 hours (or such shorter time as required by applicable law) following receipt of a prior authorization request submitted in accordance with the *Plan's* filing procedures.

If the *TPA* does not have all information it needs to make a decision, *you* will be notified within 24 hours. *You* will then have 48 hours, or longer time as granted to *you* in the notification, to provide the requested information. If *you* do not provide the requested information within the time period specified, *your* request will be denied. *You* will be notified of the decision within 48 hours after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information.

The decision may be communicated to *your* attending *provider* by telephone.

If *your* prior authorization request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- Information sufficient to identify the request involved and any information required by law;
- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the request acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals and Prior Authorization Appeals Processes" for details on requesting an appeal or external review for *claims* appeals.

B. ***Deductibles* and *Out-of-Pocket Limit*s**

NOTE: *Your* coverage is either "*covered employee* only" or "family." Therefore, only one of the following sections ("*Covered employee* only" or "Family") applies to *you*. If *you* have questions about which section applies to *you*, contact *TPA* or *your* Employer.

Covered Employee Only

***Deductibles*:** *You* must first satisfy the *deductible* by *incurring* and paying charges equal to those amounts for *eligible charges* in a *calendar year* before the *Plan* will pay *benefits*. The *Plan* will not pay *benefits* for the *eligible charges* applied toward the *deductible*. Expenses *you* pay for *coinsurance* and any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the *deductible*. *You* will not be required to satisfy the *deductible* before the *Plan* will pay *benefits* for *preventive health care services* received from a *participating provider.*

***Out-of-Pocket Limits*:** This is the amount of *deductible and coinsurance* the *covered employee* pays per *calendar year*, and is shown in the table below. *After you* have met the *out-of-pocket limit* per *calendar year*, the *Plan* covers the remaining *eligible charges incurred*. *You* must pay any amounts greater than the *out-of-pocket limit* if any *benefit* or visit maximums are exceeded. Expenses *you* pay for any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the *out-of-pocket limit*.

***Covered Employee* Only**	**Tier 1 *Participating Provider Network***	**Tier 2 *Participating Provider Network***	**Tier 3 *Non-Participating Providers***
Deductibles	The *deductibles* are combined for services received from Tier 1 and Tier 2 *participating providers.* The Tier 1 and Tier 2 *participating provider deductibles are* not combined with the Tier 3 *non-participating provider deductible.*		
	$2,500 per *calendar year* for *eligible charges* received from Tier 1 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 1 *participating provider*.*	$3,500 per *calendar year* for *eligible charges* received from Tier 2 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 2 *participating provider*.*	$7,500 per *calendar year* for *eligible charges* received from Tier 3 *non-participating providers.*

Out-of-Pocket Limits	The *out-of-pocket limits* are combined for services received from Tier 1 and Tier 2 *participating providers.* The Tier 1 and Tier 2 *participating provider out-of-pocket limits are* <u>not</u> combined with the Tier 3 *non-participating provider out-of-pocket limit.*		
	$5,000 per *calendar year* for *eligible charges* received from Tier 1 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 1 *participating provider*.*	$7,000 per *calendar year* for *eligible charges* received from Tier 2 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 2 *participating provider*.*	$10,000 per *calendar year* for *eligible charges* received from Tier 3 *non-participating providers.*

Family (*Covered Employee* and *Covered Dependents*)

Family *Deductibles*: The family must first satisfy the family *deductible* by *incurring* and paying charges equal to those amounts for eligible services in a *calendar year* before the *Plan* will pay *benefits*. The *Plan* will not pay *benefits* for the *eligible charges* applied toward the family *deductible*. Expenses *you* pay for *coinsurance* and any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the family *deductible*. *Covered persons* of the family will not be required to satisfy the family *deductible* before the *Plan* will pay *benefits* for *preventive health care services* received from a *participating provider*.

Family *Out-of-Pocket Limits*: This is the amount of *deductible and coinsurance* the family pays per *calendar year*, and is shown in the table below. After the family has met the family *out-of-pocket limit* per *calendar year,* the *Plan* covers the remaining *eligible charges incurred*. The family must pay any amounts greater than the family *out-of-pocket limit* if any *benefit* or visit maximums are exceeded. Expenses the family pays for any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the family *out-of-pocket limit.*

Family (*Covered Employee* and *Covered Dependents*)	Tier 1 *Participating Provider Network*	Tier 2 *Participating Provider Network*	Tier 3 *Non-Participating Providers*
Family *Deductibles*	The family *deductibles* are combined for services received from Tier 1 and Tier 2 *participating providers.* The family Tier 1 and Tier 2 *participating provider deductibles are* not combined with the Tier 3 *non-participating provider deductible.*		
	$5,000 per family per *calendar year* for *eligible charges* received from Tier 1 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 1 *participating provider*.*	$7,000 per family per *calendar year* for *eligible charges* received from Tier 2 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 2 *participating provider*.*	$15,000 per family per *calendar year* for *eligible charges* received from Tier 3 *non-participating providers*.
Family *Out-of-Pocket Limits*	The family *out-of-pocket limits* are combined for services received from Tier 1 and Tier 2 *participating providers.* The family Tier 1 and Tier 2 *participating provider out-of-pocket limits are* not combined with the Tier 3 *non-participating provider out-of-pocket limit.*		
	$10,000 per family (not to exceed $8,250 per *covered person*) per *calendar year* for *eligible charges* received from Tier 1 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 1 *participating provider*.*	$14,000 per family (not to exceed $8,500 per *covered person*) per *calendar year* for *eligible charges* received from Tier 2 *participating providers*, charges calculated for Tier 3 *non-participating providers* of *emergency services*, charges calculated for Tier 3 *non-participating providers* of air ambulance services, and charges calculated for Tier 3 *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a Tier 2 *participating provider*.*	$20,000 per family (not to exceed $10,000 per *covered person*) per *calendar year* for *eligible charges* received from Tier 3 *non-participating providers*.

Cost Sharing. The *provider's* allowed charge is the full amount that the *provider* bills less any discount negotiated by or on behalf of Aspirus Health Plan, Inc. with the *provider*. The calculation of the *coinsurance* is based on the least of the *provider's* allowed charge, the *fee schedule* negotiated by or on behalf of the *Plan* with the *participating provider*, or the *usual and* *customary amount*, except for: (1) the calculation of the *coinsurance* for *emergency services* provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*; (2) the calculation of the *coinsurance* for air ambulance services provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the lesser of the *qualifying payment amount* and billed charges; and (3) the calculation of the *coinsurance* for *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*.* The *deductible* is first subtracted from the allowed charge, *fee schedule*, or the *usual and customary amount*, the *recognized amount,* or the amount calculated for air ambulance services provided by a *non-participating provider* whichever is applicable, then the *coinsurance* percentage is applied to the remainder.

* If a *non-participating provider* provides non-*emergency health care services* at a *hospital* or ambulatory surgical center which is a *participating provider* and the *non-participating provider* has satisfied the notice and consent requirements described in section IV.P. of this *SPD* entitled "Balance Billing," then the Aspirus Health Plan, Inc. will pay for charges for such non-*emergency health care services* according to the terms of the *non-participating provider benefit* in the table in section VI.L. entitled "*Hospital* Services," and any amounts paid by *you* toward the *deductible* and as *coinsurance* for charges for such non-*emergency health care services* will count toward the *deductible* and *out-of-pocket limit* for *non-participating providers*.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount,* when applicable.*

C. Ambulance Services

Ambulance services for an *emergency.*	85% of *eligible charges* after the *deductible.*	85% of *eligible charges* after the Tier 1 *participating provider deductible.*	85% of *eligible charges* after the Tier 1 *participating provider deductible.**
Non-*emergency* transportation. **Note:** Prior authorization is recommended for non-*emergency* transportation	85% of *eligible charges* after the *deductible.*	85% of *eligible charges* after the Tier 1 *participating provider deductible.*	85% of *eligible charges* after the Tier 1 *participating provider deductible.*

* **Air ambulance services.** Covered air ambulance services provided by a *non-participating provider* are subject to the same *deductible* and *coinsurance* requirements that would apply if the services were provided by a *participating provider* of air ambulance services. The *deductible* and *coinsurance* requirements must be calculated as the lesser of the *qualifying payment amount* and the billed amount for the services.

Ambulance services for an *emergency*. The *Plan* covers ambulance service and *emergency* transportation to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance is covered only when the condition is an acute medical *emergency* and is authorized by a *physician*.

The *Plan* covers *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician*.

Ambulance services for a non-*emergency*. Non-*emergency* ambulance service, from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted. Transfers from a *hospital* to other facilities for subsequent covered care or from home to *provider* offices or other facilities for outpatient treatment procedures or tests or for hospice care are covered if medical supervision is required en route.

Prior authorization is recommended for:

- Non-*emergency* ambulance service, from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted; and
- Non-*emergency* transfers by ambulance from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests when medical supervision is required en route.

Exclusions:

a. Please see the section entitled “Exclusion List.”
b. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

Benefits	**Tier 1 *Participating Provider Network Plan* Payment:**	**Tier 2 *Participating Provider Network Plan* Payment:**	**Tier 3 *Non-Participating Provider Plan* Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

D. Autism Services			
Services to diagnose and treat Autism. **Note**: Some services that may be provided during an office visit may be subject to the *deductible,* such as, but not limited to, laboratory and pathology.	**<u>Office Visits:</u>** **Primary Care:** 85% of *eligible charges* after the *deductible*. ***Specialist*:** 85% of *eligible charges* after the *deductible*. **<u>*Hospital* Services:</u>** 85% of *eligible charges* after the *deductible*.	**<u>Office Visits:</u>** **Primary Care:** 75% of *eligible charges* after the *deductible*. ***Specialist*:** 75% of *eligible charges* after the *deductible*. **<u>*Hospital* Services:</u>** 75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers autism services for *covered persons* who have a primary verified diagnosis of autism spectrum disorder, which includes autistic disorder, Asperger's syndrome, childhood disintegrative disorder, Rett syndrome, and pervasive development disorders not otherwise specified. A verified autism spectrum disorder diagnosis determination must be made by a *health care practitioner* skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. We may require confirmation of the primary diagnosis through completion of empirically validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior and direct observation of the *covered person*.

Covered Autism Services:

1. **Diagnostic testing**. The testing tools used must be appropriate to the presenting characteristics and age of the *covered person* and empirically valid for diagnosing autism spectrum disorders consistent with the criteria provided in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. We reserve the right to require a second opinion with a *provider* mutually agreeable to the *covered person* and the *Plan*.
2. **Intensive-level services.** The intensive-level services must be all of the following:
   a. Evidence-based.
   b. Provided and prescribed by a licensed health care professional acting within the scope of their license (if applied behavioral analysis (ABA), preferably a board-certified behavior analyst (BCBA).
   c. Based on a treatment plan developed by a qualified *provider* or professional and updated at least every six months with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that *you* be present and engaged in the intervention.
   d. Provided in an environment most conducive to achieving the goals of *your* treatment plan.
   e. Assessed and documented throughout the course of treatment. We may request and review *your* treatment plan and the summary of progress on a periodic basis to review ongoing therapy and evaluate whether or not treatment remains *medically necessary*.
   f. Designed to include training and consultation, participation in team meetings and active involvement of the *covered person's* family and treatment team for implementation of the therapeutic goals developed by the team
3. **Concomitant services by a qualified therapist**. We will cover services by a qualified therapist when all the following are true:
   a. The services are provided concomitant with intensive-level evidence-based behavioral therapy;
   b. *You* have a primary diagnosis of an autism spectrum disorder;

c. *You* are actively receiving behavioral services from a qualified intensive-level *provider* or qualified intensive-level professional; and
d. The qualified therapist develops and implements a treatment plan consistent with their license and this section.

4. **Non-intensive-level services.** *You* are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified *provider*, supervising *provider*, professional, therapist or paraprofessional under one of the following scenarios: (i) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level *treatment*; or (ii) if *you* have not and will not receive intensive-level services but non-intensive-level services will improve *your* condition. Non-intensive-level services must be all of the following:

   a. Based upon a treatment plan and include specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that *you* be present and engaged in the intervention.
   b. Implemented by qualified *providers*, qualified supervising *providers*, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
   c. Provided in an environment most conducive to achieving the goals of *your* treatment plan.
   d. Designed to provide training and consultation, participation in team meetings and active involvement of the *covered person's* family in order to implement therapeutic goals developed by the team.
   e. Designed to provide supervision for qualified professionals and paraprofessionals in the treatment team.
   f. Assessed and documented throughout the course of treatment. We may request and review *your* treatment plan and the summary of progress on a periodic basis.

Exclusions:

a. Acupuncture, except when used in place of anesthesia and provided in connection with other *health care services* covered under this plan.
b. Animal-based therapy including hippotherapy.
c. Auditory integration training.
d. Chelation therapy.
e. Childcare fees.
f. Cranial sacral therapy.
g. Hyperbaric oxygen therapy.
h. *Custodial care* or *respite care.*
i. Special diets or supplements.
j. *Provider* travel expenses.
k. Therapy, treatment or services when provided to a *covered person* who is residing in a *residential treatment facility*, inpatient treatment or day treatment facility.
l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of *your* home.
m. *Claims* that have been determined to be fraudulent by the *Plan.*
n. Treatment provided by parents or legal guardians who are otherwise qualified *providers*, supervising *providers*, therapists, professionals or paraprofessionals for treatment provided to their own children.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

E. Chiropractic Services			
Services to treat musculoskeletal conditions by manual manipulation therapy.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

NOTE: For coverage of other therapy services, please refer to the section entitled "Physical Therapy, Occupational Therapy and Speech Therapy"

Diagnostic services are limited to *medically necessary* radiology. Treatment is limited to conditions related to the spine or joints.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Maintenance care*.
c. Blood, urine or hair analysis.
d. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
e. Manipulation under anesthesia.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

F. Dental Services

Accidental Dental Services. Treatment must begin within six months and be completed within twelve months of the date of the *injury*.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Medically Necessary Outpatient Dental Services and Hospitalization for Dental Care.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

This section does not provide coverage for preventive dental procedures. The *Plan* considers dental procedures to be services rendered by a *dentist* or *dental specialist* to treat the supporting soft tissue and bone structure.

The *Plan* covers the following dental services**:**

1. **Accidental Dental Services**. Services to treat and restore damage done to sound, natural teeth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only, not for cracked or broken teeth that result from biting or chewing. A sound, natural tooth is a tooth without pathology (including supporting structures) rendering it incapable of continued function for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair must be started within six months and completed within 12 months of the date of the *injury*, except when medical or dental conditions preclude completion of treatment within this time period.
2. ***Medically Necessary*** **Dental Services**. Dental services required for treatment of an underlying medical condition (e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions) and provided by a *dentist* or *dental specialist,* including general anesthesia, regardless of whether the services are provided in a *hospital* or a dental office. The *Plan* covers sealants on existing teeth prior to chemotherapy and the surgical extraction of impacted, unerupted teeth.
3. ***Medically Necessary*** **Hospitalization for Dental Care.** The *Plan* covers hospitalization for dental care. This is limited to charges *incurred* by a *covered person* who: a) is a child under age five; b) is severely disabled; or c) has a medical condition that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or *dental specialist* professional fees are not covered for dental services provided except as described in item 2 above. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician* or by a *dentist* or *dental specialist*.
4. **Medical complications of Dental Care.** Coverage is provided for medical complications due to dental care. Treatment must be *medically necessary* care and related to medical complications of non-covered dental care, including complications to the head, neck or substructures.
5. **Oral Surgery.** Coverage includes related consultation, x-rays and anesthesia. Coverage is limited to the following procedures:
   a. Surgical removal of impacted, unerupted teeth;
   b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   c. Surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   d. Apicoectomy (excision of the apex of the tooth root);
   e. Root canal therapy, if performed simultaneously with an apicoectomy;

f. Excision of exostosis (bony outgrowth) of the jaws and hard palate;
g. Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);
h. Incision and drainage of cellulitis (tissue inflammation) of the mouth;
i. Incision of accessory sinuses, salivary glands or ducts;
j. Gingivectomy (excision of gum tissue to eliminate infection), but not including restoration of gum tissue or soft tissue;
k. Alveolectomy;
l. Orthognathic surgery; and
m. Reduction of fractures and dislocations of the jaw.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Dental services covered under a separate dental plan offered by the same *Plan Sponsor* that offers this *SPD*.
c. Preventive dental procedures.
d. *Health care services* or dental services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as covered for accidental *injury*, *medically necessary* dental services and *hospital* facility fees and anesthesia covered under this "Dental Services" section of this *SPD*.
e. Orthodontia and all associated expenses.
f. Removal of a tooth root without the removal of the whole tooth.
g. Root canal therapy, except when performed simultaneously with an apicoectomy.
h. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay, except as covered under this "Dental Services" section of this *SPD*.
i. Dental implants or other implant-related procedures.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered by the *Plan*.
k. *Health care services* or dental services related to periodontal disease, except as covered for *hospital* facility fees and anesthesia covered under this "Dental Services" section of this *SPD*.
l. Occlusal adjustment or occlusal equilibration.
m. Treatment of bruxism.

Benefits	**Tier 1 *Participating Provider Network Plan* Payment:**	**Tier 2 *Participating Provider Network Plan* Payment:**	**Tier 3 *Non-Participating Provider Plan* Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

G. Durable Medical Equipment ("DME") Services, Prosthetics, and Orthotics

DME.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Orthotics.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Prosthetics. Limited to one purchase every three years for the standard model (as determined by the *Plan Administrator*) of each type of *prosthetic*.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Enteral feeding supplies	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Medically necessary oral nutritional and electrolyte substances administered via enteral feeding.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Insulin pump, limited to one pump per *covered person* per *calendar year*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Diabetic supplies Coverage includes over-the-counter diabetic supplies, including glucose monitors (limited to one per *covered person* per *calendar year)*, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Diabetic shoes, as *medically necessary.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
Custom-molded foot orthotics, as *medically necessary*	Coverage is limited to one pair of custom-molded foot orthotics per *covered person* per *calendar year.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers equipment and *health care services* ordered by a *physician* and provided by DME/prosthetic/orthotic vendors. For verification of eligible equipment and supplies, contact Customer Service at the address and phone number shown on the inside cover of this *SPD*. Contact lenses are eligible for coverage only when prescribed as *medically necessary* for the treatment of keratoconus, aphakia, or following cataract surgery. *Covered persons* must pay for lens replacement.

Payment is limited to the most cost effective and *medically necessary* alternative. When *you* purchase a model that is more expensive than what is considered *medically necessary* by *TPA*'s medical director, *you* will be responsible for the difference in purchase and maintenance cost**.** The *Plan's* payment for rental shall not exceed the purchase price, unless the *Plan* has determined that the item is appropriate for rental only. The *Plan* reserves the right for its medical director to determine if an item will be approved for rental or purchase.

If *you* purchase new equipment or supplies when *TPA*'s medical director determines that repair costs of *your* current equipment or supplies would be more cost effective, then *you* will be responsible for the difference in cost.

We will provide coverage for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by the *Plan Administrator*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Any durable medical equipment or supplies not listed as eligible on the *TPA's* durable medical equipment list, or as determined by the *Plan Administrator*.
c. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage. This exclusion does not apply to catheters, diabetic supplies or other medical supplies identified as eligible supplies in the Medical Policy on Durable Medical Equipment and Supplies which can be found on our member website at www.aspirushealthplan.com or by contacting Customer Service.
d. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
e. Repair or replacement of durable medical equipment and prosthetics less than three years after original purchase, except for insulin pumps and glucose monitors.
f. Repair or replacement of insulin pumps or glucose monitors less than one year after original purchase.
g. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
h. Replacement of equipment unless we determine it is *medically necessary.*
i. Replacement of over-the-counter batteries.
j. Duplicate or similar items.
k. Devices and computers to assist in communication and speech.
l. Durable medical equipment that we determine to be for *your* comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
m. Continuous passive motion (CPM) devices and mechanical stretching devices.
n. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
o. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
p. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
q. Over-the-counter orthotics and appliances.
r. Orthopedic shoes, unless *you* have diabetes or peripheral vascular disease.
s. Charges for sales tax, mailing and delivery.
t. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
u. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living*.
v. Durable medical equipment, orthotics and prosthetics that we determine to have special features that are not *medically necessary.*
w. Wigs, toupees, hairpieces, cranial prothesis, hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
x. Upgrades to, or replacement of, any items considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
y. Blood pressure cuffs and monitors.
z. Enuresis alarms.
aa. Trusses.
bb. Ultrasonic nebulizers.
cc. Oral appliances for snoring.

dd. Penile prosthesis, except when impotence: (1) is caused by an organic function; (2) is a complication that is a direct result of a covered surgery; or (3) is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful.
ee. Specialized prosthetics beyond the standard model, as determined by the *Plan Administrator*.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:**

H. ***Emergency Services***			
Emergency services	85% of *eligible charges* after the *deductible* for *emergency services*.	85% of *eligible charges* after the *deductible* for *emergency services*.	85% of the *out-of-network rate* after the *participating provider deductible* for *emergency services*.

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* situation that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone the clinic where *you* normally receive care. A *physician,* physician assistant or advanced practice registered nurse will advise *you* how, when and where to obtain the appropriate treatment.

Note: Services other than *emergency services* received in an emergency room are not covered. If *you* choose to receive non-*emergency health care services* in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under "Definitions of Terms Used."

Notwithstanding anything in this *SPD* to the contrary, Aspirus Health Plan, Inc. shall cover *emergency services*, whether provided by a *participating provider* or a *non-participating provider*, without the need for any prior authorization determination.

In the case of *emergency services* provided by a *non-participating provider*, *your deductible* and *coinsurance* will be calculated as if the total amount charged for such *emergency services* were equal to the *recognized amount*.

Covered services, whether provided by a *participating provider* or a *non-participating provider,* are subject to all of the *benefit* limitations set forth in this *SPD*. *You* should provide notice to the *TPA* of an admission to an inpatient facility within 48 hours, or as soon as reasonably possible. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours, or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when *you* are no longer incapacitated, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: (1) *you* are physically or mentally unable to provide the required notice; and (2) *you* are unable to provide the notice through another person.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Non-*emergency services* received in an emergency room.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

I. *Hearing Aids, Implantable Hearing Devices,* and Related Treatment	Coverage is limited to one *hearing aid* per ear every three years.		
Any of the following for *covered persons* who are certified as deaf or hearing impaired by a *provider* in accordance with accepted medical or audiological standards: a. One *hearing aid* per ear every three years, including fitting and testing b. *Implantable hearing devices*, limited to one set per lifetime. c. *Health care services* related to covered *hearing aids* and *implantable hearing devices,* including procedures for the implantation of *implantable hearing devices.* d. Post-*cochlear implant* aural therapy.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Hearing protection equipment.
c. *Hearing aid* batteries and cords.
d. Over-the-counter *hearing aids.*

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

J. *Home Care* Services	Limited to 60 *home care* visits per *covered person* per *calendar year.* Each visit by a *provider* to provide services under a *home care* plan, to evaluate *your* need for *home care,* or to develop a *home care* plan counts as one *home care* visit. Each period of up to four straight hours of *home health aide services* in a 24-hour period counts as one *home care* visit. The maximum weekly *benefits* payable for *home care* will not exceed the *benefits* payable for the total weekly *charges* for *skilled nursing care* available in a licensed *skilled nursing facility*, as determined by the *Plan Administrator*. Any visit that lasts less than 4 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for *home care* services. All visits must be *medically necessary* and all charges for *home care* services must be *eligible charges* under the terms of this *SPD*.		
Home care	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapeutic services, laboratory services, equipment, supplies and drugs, as appropriate, and other eligible home health services prescribed by a *physician*, physician assistant or advanced practice registered nurse for the care and treatment of *your sickness* or *injury* and rendered in *your* home up to the visit limits stated above.

You must be *homebound* for care to be received in *your* home, unless the *Plan Administrator* deems the care medically appropriate, and/or that the care is more cost effective than care in a facility or clinic.

The *Plan* covers *home care* services, including:

1. Home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate *you* for an independent treatment plan.
2. Part-time or intermittent home nursing care by or under supervision of a registered nurse.
3. Part-time or intermittent home health aide services that consist solely of care for the patient as long as they are: (1) *medically necessary*; (2) appropriately included in the *home care* plan; (3) necessary to prevent or postpone *confinement* in a *hospital* or *skilled nursing facility*; and (4) supervised by a registered nurse or medical social worker.
4. Physical or occupational therapy or speech-language pathology or respiratory care.
5. Medical supplies and *prescription drugs* prescribed by an *attending health care professional* and laboratory services by or on behalf of a *hospital* if needed under the *home care* plan. These items are covered to the extent they would be if *you* had been confined in a *hospital*.
6. Nutrition counseling provided or supervised by a registered or certified dietician.
7. Evaluation of the need for a *home care* plan by a registered nurse, *physician* extender or medical social worker. *Your attending health care professional* must request or approve this evaluation.

A service will not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed, registered nurse. Where a service (such as a tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed, registered nurse, the service will not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., service, that include skilled and non-skilled components) is covered.

The *Plan* covers palliative care *benefits* if *you* are not *homebound* up to the visit limit stated above. Palliative care includes symptom management, education, and establishing goals of care.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
c. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
d. *Health care services* and other services that can be performed by a non-medical person or self-administered.
e. Home health aides, when care in the home by a home health aide is not the most medically appropriate place of service or the most medically appropriate *provider* for those *health care services*.
f. *Health care services* and other services provided in *your* home for convenience, or due to lack of transportation.
g. *Custodial care,* except home health aide services as covered in this section.
h. *Health care services* and other services at any site other than *your* home.
i. Recreational therapy.
j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their homes.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

K. Hospice Care			
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers hospice services provided to *you* following the diagnosis of a terminal illness. *You* must meet the eligibility requirements of the program and elect to receive services through the hospice program. Hospice care may be provided at hospice facilities or in *your* home, with inpatient care available when *medically necessary* as described below. If *you* elect to receive hospice services, *you* do so in lieu of curative or restorative treatment for *your* terminal illness for the period *you* are enrolled in the hospice program.

1. **Eligibility.** In order to be eligible to be enrolled in the home hospice program, *you* must:

   a. Be terminally ill with a certification from a *physician,* physician assistant or advanced practice registered nurse; and
   b. Have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment, or treatment attempting to cure the disease or condition).

   You may withdraw from the home hospice program at any time.

2. ***Covered Services***. Hospice services include the following services, provided in accordance with an approved hospice treatment plan:

   a. Part-time (defined as up to two hours of service per calendar day) care by an interdisciplinary hospice team (which might include a *physician*, nurse, social worker, spiritual counselor or other licensed *provider*) and home health aide services, if prior authorized by the *Plan Administrator*.
   b. One or more periods of continuous care in *your* home or in a setting that provides day care for pain or symptom management, when *medically necessary*, as determined by the *Plan Administrator*. Continuous care may be provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.
   c. *Medically necessary* inpatient services.
   d. Respite care for caregivers in *your* home or in an appropriate setting. Respite care should be prior authorized by the *Plan Administrator* to give *your* primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain *you* at home.
   e. *Medically necessary* medications for pain and symptom management, if prior authorized by the *Plan Administrator*.
   f. *Hospital* beds and other durable medical equipment when *medically necessary* and should be prior authorized by the *Plan Administrator*.
   g. Bereavement counseling.

   Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
c. Respite or rest care, except as specifically described in this section.
d. Room and board for residential care at a "hospital" facility.

Benefits	**Tier 1 *Participating Provider Network Plan* Payment:**	**Tier 2 *Participating Provider Network Plan* Payment:**	**Tier 3 *Non-Participating Provider Plan* Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*
L. *Hospital* Services	**Note**: Each *covered person's confinement*, including that of a covered newborn child, is separate and distinct from the *confinement* of any other *covered person*. If *you* have *covered employee* only coverage, on the date of birth of a newborn, *you* and *your* new *covered dependent(s)*, when enrolled, become subject to the terms and conditions of family coverage.		
• Inpatient *hospital* services. • Inpatient maternity services. • Inpatient *hospital* and *residential treatment facility* services for mental and substance use disorders.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Outpatient *hospital* services, ambulatory care or surgical facility services. • Outpatient *hospital*, partial *hospital*, and rehabilitation services in a day *hospital* program for mental and substance use disorders. • Telemedicine.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Diagnostic imaging, including x-ray and ultrasound. • Laboratory tests and pathology.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Enhanced radiology, including MRI, MRA, PET scan, CT scan, and SPECT scans of back, hips and knees.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

• Cardiac rehabilitation services, including inpatient Phase I and outpatient Phase II. • Cognitive rehabilitation therapy. • Pulmonary rehabilitation therapy.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Prenatal care except when covered as a *preventive health care service* under the *"Preventive Health Care Services"* section of this *SPD*.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• *Medically necessary* genetic testing determined by the *Plan Administrator* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Elective sterilization procedures for male *covered persons.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	Not covered.
• Treatment of temporo-mandibular disorder (TMD) and craniomandibular disorder (CMD).	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• *Bariatric Surgery* Services	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

* In the case of *health care services* (other than *emergency services*) furnished by a *non-participating provider* with respect to a visit at a *hospital* or ambulatory surgical center which is a *participating provider*:

1. Unless the *non-participating provider* has satisfied the notice and consent requirements described in Section IV.P. of this *SPD* entitled Balance Billing:
    a. *Your deductible* and *coinsurance* will be calculated as if the total amount charged for such non-*emergency health care services* were equal to the *recognized amount*; and
    b. The *coinsurance* percentage applied to such charges is 85%;
    c. The *Plan* will pay the amount by which the *out-of-network rate* exceeds *your* cost-sharing responsibility as determined in accordance with sections 1.a. and 1.b.
2. If the *non-participating provider* has satisfied the notice and consent requirements, then the *Plan* will pay according to the terms of the *non-participating provider benefit* in the table above.

Notify us of *your* admission to an inpatient facility within 48 hours or as soon as medically possible.

In determining maternity *benefits* for professional and *hospital* services for delivery and postnatal care, each *covered person's confinement*, including that of a newborn child, is separate and distinct from the *confinement* of any other *covered person*.

1. **Inpatient Services.** The *Plan* covers *health care services* for the treatment of acute *sickness* or *injury* that requires the level of care only available in an *acute care facility*. Inpatient services include, but are not limited to:
    a. Room and board;
    b. The use of operating rooms, intensive care facilities; newborn nursery facilities;
    c. General nursing care, anesthesia, radiation therapy, physical, speech and occupational therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related *hospital* services;
    d. *Physician* and other professional medical and surgical services;
    e. Mental health and substance use disorder services, including detoxification services;
    f. Diagnostic imaging, laboratory tests, and pathology;
    g. Professional medical and surgical services provided by an assistant surgeon, which is defined as a *physician,* certified physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistants, certified nurse midwives, or another *provider* if acting within the scope of their license.
2. **Outpatient *Hospital*, Ambulatory Surgical Center, or Surgical Facility Services.** The *Plan* covers the following *health care services* for diagnosis or treatment of *sickness* or *injury* on an outpatient basis:
    a. Use of operating rooms or other outpatient departments, rooms or facilities;
    b. The following outpatient services: general nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related outpatient services;
    c. Laboratory tests, pathology and radiology;
    d. *Physician* and other professional medical and surgical services rendered while an outpatient;
    e. Mental health and substance use disorder services;
    f. Psychotherapy and nursing services provided in the home if authorized by the *Plan Administrator*;
    g. Professional medical and surgical services provided by an assistant surgeon, which is defined as a *physician,* certified physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistants, certified nurse midwives, or another *provider* if acting within the scope of their license;
    h. *Medically necessary* genetic testing determined by the *Plan Administrator* to be *covered services*, as described below:
        i. *You* display clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and
        ii. The result of the test will directly impact the current treatment being delivered to *you*; and
        iii. After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.
    i. Prenatal care except when covered as a *preventive health care service* under the *"Preventive Health Care Services"* section of this *SPD.*
    j. *Biofeedback*.
    k. Telemedicine services.

l. *Health care services* (including diagnostic procedures, surgical services and non-surgical treatment for the correction of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) if all of the following apply:
   - The disorder is caused by congenital, developmental or acquired deformity, *sickness* or *injury*;
   - The *health care service* is *medically necessary*; and
   - The purpose of the *health care service* is to control or eliminate infection, pain, disease or dysfunction.

   TMD splints are *eligible charges* under the Durable Medical Equipment (DME) *benefit*.

The *Plan* also covers *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services* and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD*.

3. **Rehabilitation Services in a Day *Hospital* Program.** The *Plan* covers rehabilitation services in a day *hospital* program. Coverage is limited to services for *rehabilitative care* in connection with a *sickness* or *injury*.

4. **Cardiac Rehabilitation Services.** The *Plan* covers the following cardiac rehabilitation services:
   a. Phase I cardiac rehabilitation sessions while *you* are confined as an inpatient in a *hospital;* and
   b. Phase II cardiac rehabilitation sessions while *you* are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

5. **Cognitive Rehabilitation Therapy.** The *Plan* covers outpatient cognitive rehabilitation therapy following a brain *injury* or cerebral vascular accident.

6. **Treatment of Cleft Lip and Cleft Palate.** We cover treatment of cleft lip and cleft palate for a *covered dependent* child if treatment is scheduled or started prior to the *covered dependent* child reaching age 19. Treatment includes orthodontic treatment, oral surgery and dental services directly related to the cleft. If a *covered dependent* child is also covered under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.

7. **Pulmonary Rehabilitation.** The *Plan* covers outpatient pulmonary rehabilitation therapy.

8. **Court-Ordered Services**. The *Plan* covers mental health evaluations and treatment ordered by a court under a valid court order when the services ordered are covered under this *SPD* and:
   a. The court-ordered behavioral care evaluation is performed by a *participating provider* and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.

   b. The treatment is provided by a *participating provider* or another *provider* as required by rule or law and is based on a behavioral care evaluation that meets the criteria of paragraph a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

   The *Plan* must receive a copy of any court order and evaluation. The *Plan Administrator* may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

9. **Bariatric Surgery.** Surgical treatment of *morbid obesity*. Such treatment must be used to treat the *sickness* of a *covered person.* Limited to one surgical treatment per lifetime, except when due to complications from a prior *bariatric surgery*. *Covered services* also include the first consultation visit, even if the surgery itself is not approved as a *covered service.* If the surgery is approved, all *covered services* received in preparation for surgery (e.g. qualified practitioner-guided weight loss program, x-ray/lab tests, etc.) will be considered a *covered service* by the plan. *We* recommend that *you* or *your provider* request prior authorization for *bariatric surgery* in advance of receiving services. See section VI. Prior Authorization for additional information.

   The below criteria will be followed by the medical review area to determine coverage:

   a. *Your* body mass index (BMI) must meet the definition of *morbid obesity* as contained in this *Plan*;
   b. *You* must have attempted a physician-guided weight loss program within the past year and for at least a six-month period;
   c. There is no specifically correctable cause for *morbid obesity* that would otherwise have been covered under the *Plan* (e.g., endocrine disorder);
   d. *You* are at least 20 years of age; and

   Surgical intervention is limited to once per lifetime. If an urgent or *emergency* medical admission is required due to complications of this surgery, the *Plan* will cover one additional surgical intervention to repair the original surgery.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

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

In addition, a group health plan or health issuer may not, under federal law, require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Travel, transportation, other than ambulance transportation, or living expenses.
c. Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
d. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
e. Orthoptics and surgery for refractive conditions correctable by contacts or glasses, i.e., lasik surgery
f. *Health care services* for gender reassignment, except when *medically necessary*.
g. Genetic testing and associated *health care services*, except as covered under this *SPD.*
h. Hypnosis.
i. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
j. Routine foot care, unless required due to diabetes or peripheral vascular disease.
k. Autopsies.
l. Services or items for personal convenience, such as television rental.
m. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services.*
n. Nutritional counseling, except as provided under the "Office Visits" and "*Preventive Health Care Services"* sections of this *SPD.*
o. Marital counseling, relationship counseling, family counseling except as covered under this *SPD*, or other similar counseling or training services.
p. Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
q. Counseling, studies, *confinements, health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator* except as covered under this "*Hospital* Services" section of this *SPD*.
r. *Health care services* which are court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this *Plan*. This *Plan* does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.
s. Cardiac rehabilitation beyond Phase II.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.

M. *Infertility* Services			
• Diagnostic services.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Medical services for the treatment of infertility	Coverage for artificial reproductive technology services for *infertility* is limited to a combined maximum *Plan* payment of $40,000 per lifetime for medical services and *prescription drugs.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• *Prescription drugs* for the treatment of *infertility*	See the "*Prescription Drug Services*" section of this *SPD*.		

The *Plan* covers professional services necessary to diagnose *infertility,* and the related tests, facility charges and laboratory work related to eligible services, such as but not limited to diagnostic radiology, laboratory services, semen analysis, and diagnostic ultrasounds.

Coverage for *infertility* treatment, including artificial reproductive technologies such as artificial insemination (AI), intrauterine insemination (IUI), and/or super-ovulatory drugs, is limited to a maximum *plan* payment of $40,000 per lifetime for medical services and *prescription drugs* combined.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Reversal of voluntary sterilization.
c. Adoption costs.
d. *Health care services* related to surrogate pregnancy for a person who is not a *covered person* under this *SPD*.
e. Sperm, ova or embryo acquisition, retrieval or storage.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

N. Office Visits

• *Sickness or injury* – Primary care, *specialist* and other practitioner (nurse, *physician*) office visits related to diagnosis, care or treatment of a medical, mental health or substance use related condition, *sickness* or *injury.* • Telemedicine. • Allergy visits.	**Primary Care:** 85% of *eligible charges* after the *deductible*. ***Specialist*:** 85% of *eligible charges* after the *deductible*.	**Primary Care:** 75% of *eligible charges* after the *deductible*. ***Specialist*:** 75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Diagnostic imaging and enhanced radiology, including magnetic resonance imaging and computing tomography. • Laboratory tests and pathology.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Surgical Services.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• *Virtual Care*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	Not covered.
• *Convenience Care Center.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	Not covered.
• *Urgent Care Center.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Allergy injections with no office visit.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Elective sterilization procedures for male *covered persons.*	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	Not covered.
• Treatment of temporo-mandibular disorder (TMD) and craniomandibular disorder (CMD)	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

• Genetic counseling provided to you by a *provider*, a licensed or Master's trained genetic counselor or a medical geneticist. • *Medically necessary* genetic testing determined by the *Plan Administrator* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers the professional medical and surgical services of licensed: *physicians*, physician assistants, advanced practice registered nurse and other health care *providers*.

1. Services are provided for the following:
   a. Office visits relating to the diagnosis, care or treatment of a condition, *sickness* or *injury* or certain routine services.
   b. Treatment of diagnosed Lyme disease.
   c. Contact lenses and their related fittings are not eligible for coverage unless they are prescribed as *medically necessary* for the treatment of aphakia following cataract surgery or treatment of keratoconus. If prescribed for keratoconus, *your* first set of contact lenses and their fitting are *eligible charges* under the DME *benefit*. *You* must pay for lens replacement.
   d. Diagnostic imaging (such as x-rays, CT/PET scans, MRIs), laboratory tests, and pathology.

2. Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, treatment of a minor (including family therapy but only for treatment of a minor), and treatment of mental and nervous disorders.

3. Diagnosis and treatment of substance use disorders, including evaluation, diagnosis, therapy and psychiatric services.

4. Allergy testing and injections, including serum.

5. Surgical services performed in the office.

6. *Health care services* (including diagnostic procedures, surgical services and non-surgical treatment for the correction of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) if all of the following apply:
   a. The disorder is caused by congenital, developmental or acquired deformity, *sickness* or *injury*;
   b. The *health care service* is *medically necessary*; and
   c. The purpose of the *health care service* is to control or eliminate infection, pain, disease or dysfunction.

   TMD splints are *eligible charges* under the Durable Medical Equipment (DME) *benefit*.

7. Diabetic outpatient self-management training and education, including medical nutrition therapy received from a *provider* working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

8. Nutritional counseling that is (1) for treatment of a *sickness* or *injury;* and (2) provided by a *health care practitioner,* dietitian or nutritionist licensed in the state where the counseling is provided to *you.* Nutritional counseling billed as educational services will not be covered, except as noted in the *"Preventive Health Care Services"* section of this *SPD*.

9. An *emergency* examination of a child ordered by judicial authorities.

10. Court-ordered services. The *Plan* covers mental health evaluations and treatment ordered by a court under a valid court order when the services ordered are covered under this *SPD* and:
    a. The court-ordered behavioral care evaluation is performed by a *participating provider* and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
    b. The treatment is provided by a *participating provider* or another *provider* as required by rule or law and is based on a behavioral care evaluation that meets the criteria of paragraph a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

    The *Plan* must receive a copy of any court order and evaluation. The *Plan Administrator* may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

11. Telemedicine services.

12. Treatment of Cleft Lip and Cleft Palate. We cover treatment of cleft lip and cleft palate for a *covered dependent* child if treatment is scheduled or started prior to the *covered dependent* child reaching age 19. Treatment includes orthodontic treatment, oral surgery and dental services directly related to the cleft. If a *covered dependent child* is also covered under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.

13. Prenatal care except when covered as a *preventive health care service* under the *"Preventive Health Care Services"* section of this *SPD*.

14. *Comprehensive postnatal visits* except when covered as a *preventive health care service* under the "*Preventive Health Care Services"* section of this *SPD.*

The *Plan* also covers *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD* and not this section of the *SPD*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Health education, except when:
   1. Provided during an office visit for non-*preventive health care services*; or
   2. It is counseling that is treated as a *preventive health care service*.
c. Any weight loss programs and related *health care services* that are not received from *participating providers*, or otherwise covered as *preventive health care services.*
d. Nutritional counseling, except as provided under the "Office Visits" and "*Preventive Health Care Services"* sections of this *SPD.*
e. Marital counseling, relationship counseling, family counseling, or other similar counseling or training services except as covered under this *SPD*.
f. Professional sign language and foreign language interpreter services in a *provider's* office.
g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by the *Plan Administrator*.

i. Genetic testing and associated *health care services*, except as covered under this *SPD*.
j. Hypnosis.
k. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
l. Routine foot care, unless required due to diabetes or peripheral vascular disease.
m. Vision therapy/orthoptics.
n. *Health care services* which are court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this *Plan*. This *Plan* does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

Benefits	***Designated Transplant Network Provider Plan* Payment:**	***Non-Designated Transplant Network Provider***
O. Organ and Bone Marrow *Transplant Services*	**Office Visits:** See the "Office Visits" section of this *SPD*. ***Hospital* Services:** See the "*Hospital* Services" section of this *SPD*.	Not covered.
Travel *Benefits* Applies to a *covered person* who is a transplant recipient or a *covered person* who is a donor if the transplant recipient is also a *covered person* under this plan. A *covered person* aged 18 and over who lives 50 or more miles from the *designated transplant network provider* is eligible for reimbursement for travel and lodging expenses for the *covered person* plus one companion. A *covered person* under age 18 who lives 50 or more miles from the *designated transplant network provider* is eligible for reimbursement for travel and lodging expenses for the *covered person*, plus up to two parents.	100% of *eligible charges*. *Deductible* does not apply. Coverage is limited to a maximum *Plan* payment of $5,000 per transplant for transportation and lodging expenses combined. *Benefits* are payable for up to one year from the date of the transplant while the *covered person* is receiving *transplant services*.	Not covered.

The *Plan* covers eligible *transplant services* that we determine to be *medically necessary* and not *investigative* but only when the *transplant services* are received at a *designated transplant network provider*. Prior Authorization is recommended in advance of receiving *transplant services*.

Coverage for organ transplants, bone marrow transplants, and bone marrow rescue services is subject to periodic review. We evaluate *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually, or as new information becomes available, and it results in specific guidelines about *benefits* for *transplant services*. *You* may call Customer Service at the telephone number listed inside the cover of this *SPD* for information about these guidelines.

If the transplant meets the definition of an *eligible charge*, is *medically necessary*, and is not *investigative*, *benefits* are available for the following eligible transplants:

1. Bone marrow transplants and peripheral stem cell transplants.
2. Heart transplants.
3. Heart/lung transplants.
4. Lung transplants.
5. Kidney transplants.
6. Kidney/pancreas transplants.
7. Liver transplants.
8. Pancreas transplants.
9. Small bowel transplants.

10. Cornea transplants.
11. Artificial or mechanical devices, if approved as a bridge to a transplant or destination therapy.
12. Stem cell transplants.

The *Plan* will cover approved *transplant services*, including but not limited to *organ and tissue acquisition* and transplantation, including any post-transplant complications, if *you* are the recipient; and related medical care, including any post-harvesting complication, if *you* are a donor. Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this *SPD.*

If *you* are a transplant recipient or if *you* are a donor and the transplant recipient is also a *covered person* under this *Plan,* and *you* live 50 or more miles away from the *designated transplant network provider* at which the covered transplant will be performed, we will pay for the following:

1. Transportation to and from the *designated transplant network provider* for *you* and
   a. a close relative or other person to accompany *you* if *you* are a *covered person* aged 18 or over; or
   b. one or two of *your* parents to accompany you if *you* are a *covered person* under age 18.

   Covered expenses for transportation to and from the *designated transplant network provider* facility include airfare, tolls, parking fees and gas/mileage.
2. Lodging at or near the *designated transplant network provider* for *you* and/or *your* family member(s) who accompanied *you* while *you* are receiving transplant-related services as such *designated transplant network provider*. Covered lodging expenses include apartment or hotel rental and applicable tax.

Payment for transportation and lodging will be limited to $5,000 and are payable for up to one year from the date of the transplant while *you* are receiving services at the *designated transplant network provider.*

Exclusions:

a. Please see the section entitled “Exclusion List.”
b. *Transplant services* received from a *provider* that is not a *designated transplant network provider.*
c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary*.
e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
g. Treatment of medical complications to a donor after procurement of a transplanted organ if the donor is not a *covered person*.
h. Computer search for donors.
i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
j. Travel expenses related to a covered transplant in excess of $5,000.
k. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.
l. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

P. Physical Therapy, Occupational Therapy, Speech Therapy, Aquatic Therapy and Respiratory Therapy			
• Physical therapy for *habilitative care.* • Physical therapy for *rehabilitative care.*	Coverage for physical therapy is limited to a maximum of 40 visits per *calendar year* unless additional visits are authorized as *medically necessary.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Occupational therapy for *habilitative care.* • Occupational therapy for *rehabilitative care.*	Coverage for occupational therapy is limited to a maximum of 40 visits per *calendar year* unless additional visits are authorized as *medically necessary.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Speech Therapy for *habilitative care.* • Speech therapy for *rehabilitative care*.	Coverage for speech therapy is limited to a maximum of 40 visits per *calendar year* unless additional visits are authorized as *medically necessary.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Aquatic Therapy	Coverage for aquatic therapy is limited to a maximum of 20 visits per *calendar year* unless additional visits are authorized as *medically necessary.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Respiratory Therapy	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The Plan covers office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative care* rendered to treat a medical condition, *sickness* or *injury,* and the *rehabilitative care* is expected to demonstrate measurable and sustainable improvement, usually within a short period of time (e.g. two weeks to three months), depending on the physical and mental capacities of the individual. We also cover office visits and outpatient PT, OT and ST *habilitative therapy* for medically diagnosed conditions. PT, OT and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a *physician*, physician assistant or certified nurse practitioner.

NOTE: *Benefits* for *health care services* administered or received in an inpatient setting are described in the "*Hospital* Services" section of this *SPD*. *Benefits* for *skilled care* administered or received in a *skilled nursing facility* are described in the "*Skilled Care* Services" section of this *SPD*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Custodial care* or *maintenance care*.
c. Therapy provided in *your* home for convenience.
d. Therapy for conditions that are self-correcting.
e. Voice training and voice therapy absent a medical condition.
f. *Investigative* therapies.
g. Group therapy for physical therapy, occupational therapy and speech therapy.
h. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
i. *Health care services* for homeopathy and immunoaugmentive therapy.

Benefits	**Drugs obtained at a pharmacy that is a *participating provider,* *Plan* Payment**

Q. *Prescription Drug* Services

Please see the *Preventive Health Care Services* section for coverage of *prescription drugs,* including certain insulin and other glucose lowering agents, on our Preventive Drug List.

***Prescription drugs* are <u>not covered</u> if obtained from a pharmacy that is <u>not a *participating provider*</u>.**

• *Prescription drugs* and supplies that can be self-administered, dispensed by a *participating provider* pharmacy for up to a 31-calendar day supply per prescription or refill. **Note:** Drugs on the "Long Term Use List" are not available to be filled in this quantity. • Diabetic Supplies dispensed by a *participating provider* pharmacy for up to a 31-calendar day supply per prescription or refill. Coverage includes over-the-counter diabetic supplies, glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary.*	**<u>Up to a 31-day Supply</u>** **Tier 1 (Generic):** 85% of *eligible charges* after the *deductible*. **Tier 2 (Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Tier 3 (Non-Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.
• Mail order *prescription drugs* and supplies dispensed by an Aspirus Mail Order Pharmacy for up to a 32-93-calendar day supply per prescription or refill. • Mail order diabetic supplies dispensed by an Aspirus Mail Order Pharmacy for up to a 32-93-calendar day supply per prescription or refill. Coverage includes over-the-counter diabetic supplies, glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary.*	**<u>32-93-day Supply</u>** **Tier 1 (Generic):** 85% of *eligible charges* after the *deductible*. **Tier 2 (Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Tier 3 (Non-Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.

• *Prescription drugs* that appear on the “Long Term Use List” and are dispensed by an Aspirus Retail Pharmacy, for a 93-calendar day supply per prescription or refill.	**<u>93-day Supply</u>** **Tier 1 (Generic):** 85% of *eligible charges* after the *deductible*. **Tier 2 (Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Tier 3 (Non-Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.
• *Prescription drugs* that appear on the “Variable Use List” and are dispensed by a *participating provider* pharmacy, for a 32 – 93 calendar day supply per prescription or refill.	**<u>32-93-day Supply</u>** **Tier 1 (Generic):** 85% of *eligible charges* after the *deductible*. **Tier 2 (Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Tier 3 (Non-Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.
• *Prescription drugs* for the treatment of *infertility*	Coverage for artificial reproductive technology services for *infertility* is limited to a combined maximum *Plan* payment of $40,000 per lifetime for medical services and *prescription drugs.*
	<u>Up to a 31-day Supply</u> **Tier 1 (Generic):** 85% of *eligible charges* after the *deductible*. **Tier 2 (Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Tier 3 (Non-Preferred Brand):** 85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.

Specialty Drugs		
Benefits	***Specialty Drugs* obtained at our designated specialty pharmacy, the *Plan* pays:** For more information, contact Customer Service.	***Specialty Drugs* obtained at any pharmacy other than a designated specialty pharmacy:**
Specialty drugs are covered at the *specialty drug* benefit level regardless of whether the *specialty drug* is otherwise classified as a generic or a brand name drug. *Benefits* for *specialty drugs* are as described in this section regardless of the place of service where the *specialty drug* is dispensed or administered. **Note:** Certain *specialty drugs* may only be available by limited distribution through the manufacturer's select specialty pharmacy and may not be available through our designated specialty pharmacy. *Benefits* for such limited distribution *specialty drugs* will be paid the same as if they were obtained from our designated specialty pharmacy.		

• *Specialty drugs* up to a 30–calendar day supply per prescription or refill that: ✓ may be oral or injectable; and ✓ Must be purchased through a specialty pharmacy. A list of these *specialty drugs* may be obtained on the designated website or by calling Customer Service. The list of *specialty drugs* may be revised from time-to-time without notice.	85% of *eligible charges* after the *deductible*. **Non-*formulary*:** Not covered.	Not covered.

If the *participating provider* pharmacy's charge is less than the *deductible*, you will only be responsible for the amount of the charge. Otherwise, you must pay any applicable *deductible* amount for each separate *prescription drug* order or refill of a covered drug or covered supply.

Preventive Contraceptives. This section does not cover or provide *benefits* for oral, injectable, insertable, *prescription drugs* and devices that are *preventive health care services* described in the "Preventive Contraceptive Methods and Counseling for Women" section of this *SPD.*

Formulary. *Plan Administrator* uses a drug *formulary* to determine which *benefit* level applies to a specific *prescription drug*. The *formulary* is subject to periodic review and modification. A current list of drugs on our *formulary* may be obtained by accessing our website at https://www.aspirushealthplan.com or by calling Customer Service.

Step Therapy. For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. *Covered persons* in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. *You* may learn more about the program requirements by calling Customer Service. Step therapy can apply to *formulary* or non-*formulary* drugs. Step therapy can also apply, regardless of tier, to generic, preferred brand, non-preferred brand, or *specialty drugs*. The Step Therapy List is subject to periodic review and modification by the *Plan Administrator*.

Over the Counter (OTC) Drugs. Certain drugs available over-the-counter are covered by the *Plan* as determined by the *Plan Administrator*. A list of such over-the-counter drugs is available upon request by contacting Customer Service. Those over-the-counter drugs that are covered by the *Plan* will require a prescription from a *physician*, physician assistant or an advanced practice registered nurse. To receive the *Plan's* payment toward *your* over-the-counter drugs, *you* must present *your* prescription at a participating pharmacy. *You* will be responsible for applicable *coinsurance* or *deductible* amounts.

Quantity Limits. Some dispensed *prescription drugs* require the use of quantity limits, which ensure that the quantity of each prescription remains consistent with clinical guidelines. Quantity limits can apply to *formulary* or non-*formulary* drugs. Quantity limits can also apply, regardless of tier, to generic, preferred brand, non-preferred brand, or *specialty drugs.* A list of those *prescription drugs* with quantity limits is available upon request. The quantity limits list is subject to periodic review and modification by the *Plan Administrator.*

Brand Name Drugs for which Generic Available. Except as provided in the "Preventive Contraceptive Methods and Counseling For Women" section of this *SPD*, if *you* request a brand name drug when a generic drug alternative is available, *you* must pay the applicable preferred brand or non-preferred brand *deductible* and *coinsurance* for the brand name drug plus the difference in cost between the brand name and the generic drug. The cost difference between the brand name and the generic drug is not applied toward *your out-of-pocket limit*.

***Formulary* Exceptions:** *You* or *your provider* may request an exception to the drug *formulary.* The *Plan* must make a determination on a standard exception request and notify *you* and the prescribing *physician* of our coverage determination no later than 72 hours following receipt of the request. Upon request, the *Plan* will perform an expedited review of the exception request if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or when *you* are undergoing a current course of treatment using a non-*formulary* drug. If the *Plan* determines that *you* qualify for an expedited review of the exception request based on these criteria, the *Plan* must make a determination on the expedited exception request and notify *you* and the prescribing *physician* of our coverage determination no later than 24 hours following receipt of the request. The *Plan* will determine if an exception applies and, if so, the non-*formulary* drugs that are approved as an exception will be covered at the same level as the *formulary* drugs.

An exception is valid for the duration of the prescription while covered under this *Plan,* including refills, except that if *you* obtained an exception based on an expedited review the exception will be valid for the duration of the circumstances that are the basis for the expedited review. *Your physician* may request the exception for subsequent prescriptions, following the procedure described above. The exception does not apply if we removed the drug from the *formulary* for safety reasons. Contact Customer Service for a copy of the written guidelines and procedures, or for assistance in requesting an exception.

***Compounded Drugs*.** *Compounded drugs* will be covered provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the *compounded drug* will be considered for coverage after documented failure of the commercially prepared product(s), unless a *formulary* exception is obtained. A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. Non-preferred brand *formulary benefits* apply. *Compounded drugs* containing any product that is excluded by the *Plan* will not be covered, including dosages and route of administration that have not been approved by the FDA.

Prescription Drugs* covered as *Preventive Health Care Services. The *Plan* covers certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act.* Our *formulary* identifies these *prescription drugs* as "Preventive." The *formulary* may be obtained by accessing our website at www.aspirushealthplan.com or by calling Customer Service. More information regarding *benefits* for *prescription drugs* that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "*Preventive Health Care Services*" sections of this *SPD.*

Off-label use of *prescription drugs*. Off-label use of *prescription* drugs may be reviewed for *medical necessity* and will only be covered if the off-label drug criteria are met.

Copay Card Solutions: The *Plan* utilizes Optum Copay Card Solutions to obtain *prescription drug* manufacturer discounts on *your* behalf. If a manufacturer copay card is available, *you* have the option to enroll with the manufacturer and use the card towards payment of *your prescription drugs*. Amounts paid by manufacturers on *your* behalf under a copay card program, along with other payments from manufacturers, such as manufacturer coupons, cannot be used to satisfy *your deductible* or *out-of-pocket limit*. If *you* do not enroll in an available copay card program, *you* will be responsible for all out-of-pocket costs associated with receiving the *prescription drug* as per your plan benefit. Call Customer Service for additional information.

90-Day *Specialty Drug* Program: At your request, certain *specialty drugs* may be made available in a 90-day supply. In order to receive a 90-day supply of a *specialty drug,* the *specialty drug* must be included on the list of *specialty drugs* approved by the *Plan* for a 90-day refill, and *you* must demonstrate stability on and adherence to the *specialty drug* regimen for a minimum of six months. *Specialty drug benefits* apply, including any *deductible* or *coinsurance*.

Split Fill Program: *Prescription drugs,* including certain oral oncology and *specialty drugs,* identified for *our* Split Fill Program, may be provided in a limited supply (e.g. 15 calendar days or less) per prescription or refill, even if prescribed for a longer period of time. For a list of drugs on the Split Fill Program, go to the member site at www.aspirushealthplan.com or call Customer Service at the toll-free phone number listed on the inside cover of this *SPD.*

Extended Day Supply Program. The *Plan* covers *prescription drugs* which *you* may need for long-term use. In addition to the mail order program, certain listed drugs may be obtained from a retail pharmacy as follows:

- **Long-Term Use List:** Prescriptions for medications that appear on the "Long-Term Use" list must be filled for a 93-day supply at a Aspirus Retail pharmacy.

- **Variable Use List:** *Prescription drugs* that appear on the "Variable Use" list are medications which may be used on either a short-term or long-term basis, or which may require more frequent dosing changes. *You* may select either a 31-calendar day supply or an extended day supply of *prescription drugs* that appear on the Variable Use list and may fill or refill *your* prescription at any *participating provider* pharmacy.

Prior Authorization. Prior authorization is required for certain *prescription drugs* before *you* fill *your* prescription at a pharmacy. The list of *prescription drugs* which require prior authorization may be found at www.aspirushealthplan.com/insurance/priorauthorization.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
c. Refill or replacement of a *prescription drug* or supply due to loss, damage, theft, spillage, spoilage or other actions that render it unusable.
d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *SPD*.
e. *Prescription drugs* that are equivalent to or similar to OTC drugs, except as provided in the drug *formulary*.
f. OTC home testing products, except diabetic supplies, glucose monitors and blood and urine test strips for diabetes, or as otherwise required to be covered under federal law.
g. Drugs not approved by the FDA, and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when the *Plan Administrator*, at its sole discretion, determines to include the drug on its *formulary* or approves coverage of the drug for the particular use.
h. Take home drugs when dispensed by a *physician,* physician assistant or advanced practice registered nurse.
i. Weight loss drugs.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *SPD*.
k. Drugs used for *cosmetic* purposes.
l. Unit dose packaging.
m. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use, but is being applied topically).
n. *Prescription drugs* given or administered as part of a drug manufacturer's study.
o. *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
p. *Prescription drugs* for the treatment of sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to *you*.
q. Off-label use of drugs determined to be *investigative*.
r. Certain *combination drugs* and other drugs if they are listed as not covered on the *formulary*.
s. *Compounded drugs* being used for bio-identical hormone replacement therapy, except as covered under this *SPD*.
t. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition, or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *SPD.*
u. Prescribed or non-prescribed vitamins or minerals including OTC, unless covered as *preventive health care services*.
v. Medicinal foods, supplemental feedings, nutritional and electrolyte supplements, and infant formula, except when *medically necessary* or as otherwise covered under section VI.G. Durable Medical Equipment ("DME") Services, Prosthetics, and Orthotics.
w. *Specialty drugs* obtained at any pharmacy other than our designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through our designated specialty pharmacy.
x. Non-*formulary* drugs, unless an exception is obtained from the *Plan Administrator.*
y. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *SPD,* except as required under state or federal law.

<table>
<tr><th>Benefits</th><th>Tier 1 Participating Provider Network
Plan Payment:</th><th>Tier 2 Participating Provider Network
Plan Payment:</th><th>Tier 3 Non-Participating Provider
Plan Payment:</th></tr>
</table>

R. Preventive Contraceptive Methods and Counseling for Women

The *Plan* covers preventive contraceptive methods and counseling services received during the *calendar year* by female *covered persons* as described in the *Preventive Health Care Services* Schedule ("Schedule") and according to the frequency and time frames stated in the Schedule.

The Schedule, which includes the preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on our website at www.aspirushealthplan.com or by calling Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, a mail order pharmacy, or received at a *provider's* office.

<table>
<tr><th colspan="3">Women's prescription contraceptives received at a retail pharmacy or mail order pharmacy:</th></tr>
<tr><td>• Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and
• Preferred brand and non-preferred brand oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.</td><td>100% of eligible charges.
Deductible does not apply.</td><td>Not covered.</td></tr>
<tr><td>• Preferred brand and non-preferred brand oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.</td><td>100% of the amount that would have been payable for the generic alternative.
Deductible does not apply.
If you request a brand name contraceptive when a generic alternative exists, you must pay the difference in cost between the brand name and the generic drug.</td><td>Not covered.</td></tr>
</table>

Benefits	**Tier 1 *Participating Provider Network Plan* Payment:**	**Tier 2 *Participating Provider Network Plan* Payment:**	**Tier 3 *Non-Participating Provider Plan* Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

Women's prescription contraceptives, sterilization procedures, and *covered person* education received at a *provider's* office:			
• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Preferred brand and non-preferred brand injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Preferred brand and non-preferred brand injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Sterilization procedures, excluding the reversal of sterilization procedures.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply.	Not covered.
• *Covered person* education and counseling about contraceptive methods.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply.	50% of *eligible charges* after the *deductible*.

Your provider may request an exception for coverage of an FDA-approved, cleared or granted contraceptive product that is not on the formulary. If such non-formulary contraceptive is a preferred brand or non-preferred brand drug for which a generic is available, once approved, *we* will pay 100% of the *eligible charges* for the preferred brand or non-preferred brand preventive contraceptive drug when *you* obtain it from a *participating provider*, and the *deductible* will not apply.

You or your *provider* may contact Customer Service for a copy of the written guidelines and procedures or for assistance in requesting an exception.

An exception is valid for the duration of the prescription while *you* are covered under this *SPD*, including refills. *Your provider* may request an exception for subsequent prescriptions following the procedure described in the *Prescription Drug* Services section. The exception does not apply if we remove the drug from the *formulary* for safety reasons. A previously granted exception ends when we remove the drug from the *formulary* for safety reasons.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Contraceptives and related *health care services* received from *non-participating providers*.
c. Sterilization procedures performed by *non-participating providers*.
d. Abortions are not covered under this section of this *SPD*.
e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
f. Hysterectomies are not covered under this section of this *SPD*.
g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures including, but not limited to, Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *SPD*.
h. Reversal of sterilization procedures.
i. Non-*preventive health care services* are not covered under this section of this *SPD*.

Benefits	**Tier 1 *Participating Provider Network Plan* Payment:**	**Tier 2 *Participating Provider Network Plan* Payment:**	**Tier 3 *Non-Participating Provider Plan* Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

S. *Preventive Health Care Services*

The *Plan* covers *preventive health care services* required under the *Affordable Care Act* that *you* receive during the *calendar year.* The services required by the *Affordable Care Act* and their frequency and time frames are stated in the *Preventive Health Care Services* Schedule ("Schedule"). The Schedule may be amended from time-to-time, on a prospective basis, and is available on our website at www.aspirushealthplan.com or by contacting Customer Service. This *SPD* also covers certain *preventive health care services* that are required by state law. They are addressed at the end of this section.

The Schedule includes certain routine services such as: • Routine physical examinations when ordered by a *physician*. • Routine laboratory tests, pathology and radiology. • Counseling for certain conditions and lactation counseling. • Purchase/rental of breast pumps. • Certain prescribed preventive medications required under the *Affordable Care Act*. • Pap tests. • Routine screenings for certain other conditions (such as abdominal aortic aneurysm, diabetes, HIV and osteoporosis).	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply	50% of *eligible charges* after the *deductible*.
• Child health supervision services as required under the *Affordable Care Act*. Coverage includes pediatric *preventive health care services,* developmental assessments, and laboratory services appropriate to the age of the child.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply	50% of *eligible charges* after the *deductible*.

• Breastfeeding equipment provided in conjunction with each birth. Breastfeeding equipment must be provided by a *participating provider.*	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• Routine immunizations.	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Colorectal screening tests, including colonoscopy and associated *medically necessary health care services*, covered at this preventive *benefit* once every five years, regardless if billed with a diagnosis or as a *preventive health care service.*	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Mammograms and other breast cancer screenings for which coverage is required under the *Affordable Care Act* covered under this preventive *benefit* once every *calendar year*, regardless if billed with a diagnosis or as a *preventive health care service.*	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Two tobacco cessation counseling program attempts per *covered person* per *calendar year*, limited to four counseling sessions per attempt.	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.

• Tobacco cessation *prescription drugs* and prescribed over-the-counter (OTC*)* medications when used in connection with or separate from a designated tobacco cessation counseling program, are limited to a total 90-calendar day supply per *covered person* per attempt for up to two attempts per *covered person* per *calendar year.*	100% of *eligible charges*. *Deductible* does not apply.		Not covered.
• All recommended, necessary preventive services, depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors, including pre-pregnancy, prenatal, postpartum, and interpregnancy visits.	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.

Preventive Health Care Services* that are in Addition to Those Required by the *Affordable Care Act			
• Prostate specific antigen (PSA) test: Covered 100% once per *calendar year* at a *participating provider*, regardless if billed with a diagnosis or as a *preventive health care service*.	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Blood lead tests	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Breast cancer screenings for which coverage is not required under the *Affordable Care Act*, covered under this preventive *benefit* once every *calendar year*, regardless if billed with a diagnosis or as a *preventive health care service.*	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Routine eye examination, with or without refractions.	100% of *eligible charges.* *Deductible* does not apply.	100% of *eligible charges.* *Deductible* does not apply.	100% of *eligible charges.* *Deductible* does not apply.

• Routine hearing examinations.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Routine prenatal care services (as defined below).	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• One routine postnatal care exam that includes a health exam, assessment, education and counseling provided during the period immediately after childbirth.	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Child health supervision services (as defined below).	100% of *eligible charges*. *Deductible* does not apply.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Advance care planning office consultations limited to one initial consultation and two follow up consultations.	100% of *eligible charges. Deductible* does not apply.	100% of *eligible charges. Deductible* does not apply.	50% of *eligible charges* after the *deductible*.
• Insulin on our Preventive Drug List for up to a 90-calendar day supply for one type of insulin per prescription or refill.	100% of *eligible charges*. *Deductible* does not apply.		Not covered.

Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education and use of routine specialized skills and technology as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months. Please refer to the *Affordable Care Act Preventive Health Care Services* schedule to determine if additional coverage is available.

Female *covered persons* may obtain annual preventive health examinations and prenatal care from obstetricians and gynecologists in the *participating provider* network, without a *referral* from another *physician,* physician assistant or advanced practice registered nurse or prior approval from the *Plan Administrator*.

Notes:

- Non-*preventive health care services* are not covered under this section of the *SPD.*
- Non-routine *health care services,* including but not limited to non-routine prenatal services, are not covered under this section of the *SPD.*

Exclusions:

a. Please see the section entitled “Exclusion List.”
b. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *SPD*.
c. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
d. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *SPD.*
e. Non-prescribed over-the-counter medications.
f. Travel immunizations.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*
T. ***Reconstructive*** **Surgery**	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers *medically necessary reconstructive* surgery that is incidental to or follows surgery resulting from *injury*, *sickness*, accident or other diseases of the involved part, or when such surgery is performed on a *covered dependent* child because of a congenital disease or anomaly which has resulted in a functional defect as determined by the attending *physician*.

Eligible charges include eligible *hospital*, medical and surgical, laboratory, pathology, radiology and facility charges. Contact Customer Service to determine if a specific procedure is covered.

The *Plan* covers *medically necessary reconstructive* surgery due to *sickness*, accident or congenital anomaly. *Eligible charges* include eligible *hospital*, *physician*, laboratory, pathology, radiology and facility charges. Contact Customer Service to determine if a specific procedure is covered.

The *Plan* also covers *reconstructive surgery following a mastectomy. Reconstructive surgery following a mastectomy* includes the following:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Services and supplies will be determined in consultation with the attending *physician* and patient. Such coverage will be subject to *coinsurance* and other plan provisions.

Women's Health and Cancer Rights Act Notice

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

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

These *benefits* will be provided subject to the same *deductibles* and *coinsurance* applicable to other medical and surgical *benefits* provided under this *Plan*. If you would like more information on WHCRA *benefits*, call your *Plan Administrator* at 1.866.631.5404.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Health care services* to treat conditions that are *cosmetic* in nature.

Benefits	**Tier 1** ***Participating Provider Network Plan*** **Payment:**	**Tier 2** ***Participating Provider Network Plan*** **Payment:**	**Tier 3** ***Non-Participating Provider Plan*** **Payment:** **Note:** For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount.*

U. *Skilled Care* Services	Limited to the first 30 days of confinement for *skilled nursing care.* **Note:** A transfer between *providers* for *skilled care* does not constitute a new *confinement* for purposes of the 30-day limitation. *You* must be admitted to the *skilled nursing facility* within 24 hours after discharge from a *hospital* or surgical center or directly from emergency room care, urgent care facility or an *attending health care practitioner's* office and *you* must be admitted to the *skilled nursing facility* for continued treatment of the same *sickness* or *injury.*		
	85% of *eligible charges* after the *deductible*.	75% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

The *Plan* covers eligible *skilled nursing facility* services for post-acute treatment and *rehabilitative care* for *sickness* or *injury*. Prior authorization is recommended for all *skilled nursing facility* stays.

Skilled nursing facility services include room and board, daily skilled nursing and related ancillary services. The *Plan Administrator* determines when care no longer meets criteria for coverage.

Only services that qualify as reimbursable under Medicare are covered *benefits*. Coverage is limited to the first 30 calendar days of *your* confinement in a *skilled nursing facility* for services that would qualify as reimbursable under Medicare.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Respite or *custodial care*.
c. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. *home care* or care in an outpatient setting).
d. Care that is available to *you* at no cost to *you* or care provided under a government health care program (other than a state Medicaid Plan or state CHIP).

VII. Exclusion List

In addition to any other exclusions or limitations specified in this *SPD*, and with the exception of autism services which has a limited list of exclusions, the *Plan* will not cover charges *incurred* for any of the following:

1. *Health care services* that the *Plan Administrator* determines are not *medically necessary*.
2. *Health care services* that the *Plan Administrator* determines are *investigative*, and associated expenses.
3. Charges for *health care services* determined by the *Plan Administrator* to be duplicate services.
4. Personal comfort or convenience items.
5. The following procedures and any related *health care services*:
   a. Injection of filling material (collagen) other than for incontinence;
   b. Salabrasion;
   c. Rhytidectomy (face lift);
   d. Dermabrasion; chemical peel;
   e. Suction-assisted lipectomy (liposuction);
   f. Hair removal, other than when *medically necessary* for gender dysphoria;
   g. Mastopexy;
   h. Mammoplasty, including augmentation or reduction mammoplasty, except for reconstruction associated with a covered mastectomy or when *medically necessary* for gender dysphoria;
   i. Correction of inverted nipples;
   j. Sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g. telangiectasias, spider veins, reticular veins);
   k. Excision or elimination of hanging skin on any part of the body, including panniculectomy, abdominoplasty and brachioplasty. This exclusion does not apply to surgical procedures that are *medically necessary* and recommended by the physician, such as but not limited to *medically necessary* blepharoplasty;
   l. Non-*medically necessary* mastectomy or mastectomy surgery performed for *cosmetic* purposes, except as provided in the *"Reconstructive* Surgery" section of this *SPD* or as required under the Women's Health and Cancer Rights Act (WHCRA) of 1998;
   m. Botulinum toxin or similar products, unless *you* receive prior authorization;
   n. Any modification to the body that does not affect its function;
   o. Labiaplasty, except when *medically necessary* for gender dysphoria;
   p. Treatment of sialorrhea (drooling or excessive salivation); and
   q. *Health care services,* including surgical services for the treatment of excessive sweating (hyperhidrosis).
6. *Oral surgery*, except as covered under the "Dental Services" section of this *SPD*.
7. *Health care services* received before *your* coverage with the *Plan* begins or after *your* coverage under the *Plan* ends.
8. *Health care services* not directly related to *your* care.
9. *Health care services* a *provider* ordered or that are rendered by *providers* that are unlicensed or not certified by the appropriate state regulatory agency.
10. *Health care services* not rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate. *You* are encouraged to consult with *your provider* regarding the most cost-efficient setting or methodology appropriate for *your sickness* or *injury*.
11. Charges that exceed the *usual and customary amount* for *health care services* received from *non-participating providers*, including *non-participating provider* pharmacies.
12. *Health care services* prohibited by law or regulation, or illegal under applicable laws.
13. Vision lenses, frames and eyeglasses.
14. Contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.
15. Any *health care services* provided by a relative (i.e., a spouse, parent, brother, sister or child of the *covered person* or of the *covered person's* spouse) or anyone who customarily lives in the *covered person's* household.
16. *Health care services* provided by massage therapists, doulas and personal trainers.

17. *Health care services* provided by *providers* who have not completed professional level education and licensure as determined by the *Plan Administrator*.
18. *Health care services* for the treatment of sexual dysfunction for both male and female *covered person*, including impotence, regardless of the cause of the dysfunction. This includes: (a) *surgical services;* (b) devices; (c) drugs for, or used in connection with, sexual dysfunction; and (d) sex therapy. This exclusion does not apply to penile implants as covered under the Durable Medical Equipment ("DME") Services, Prosthetics and Orthotics section of this *SPD*.
19. Massage therapy.
20. Preventive medical services and supplies not ordered by a *provider*, including, but not limited to, cholesterol testing, glucose testing and mammograms, unless specifically listed in the schedule of *Preventive Health Care Services* or provided by a *participating provider*.
21. Any charges or loss to which a contributing cause was the *covered person's* commission of or attempt to commit a felony, if such action results in felony charges, or to which a contributing cause was the *covered person* being engaged in an illegal occupation. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition such as alcoholism.
22. Financial or legal counseling services.
23. Elective abortions, except for abortion procedures permitted by and performed in accordance with law in situations where the life of the mother would be endangered if the fetus was carried to full term, or due to a *lethal fetal anomaly,* or in cases of rape or incest.
24. Travel, transportation or living expenses, except as provided under the "Ambulance Services" and "Organ and Bone Marrow *Transplant Services*" sections of this *SPD*.
25. Photodynamic therapy and laser therapy for the treatment of acne.
26. Homeopathic, holistic or naturopathic medicine, including dietary supplements.
27. Drugs and medical devices that are only approved for compassionate use by the United States Food & Drug Administration.
28. Costs associated with *clinical trials* that are not *routine patient costs.*
29. *Non-emergency health care services* performed directly in connection with the performance of non-*covered health care services*.
30. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise *medically necessary*, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.
31. *Health care services* provided in connection with any *sickness* or *injury* arising out of, or sustained in the course of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance, This exclusion applies regardless of whether *benefits* under workers' compensation laws or any similar laws have been claimed, paid, waived or compromised.
32. *Health care services* furnished by the U.S. Veterans Administration, unless federal law designates the *SPD* as the primary payor and the U.S. Veterans Administration as the secondary payor.
33. *Health care services* furnished by any federal or state agency or a local political subdivision when *you* are not liable for the costs in absence of insurance, unless such coverage under the *SPD* is required by law.
34. Halfway houses, (except *covered services* provided to *you* at a halfway house), extended care facilities, community based residential facilities, group homes, or comparable facilities, foster care, adult foster care, and family childcare.
35. Sterilization reversals.
36. Nutritional and food supplements except as otherwise covered under the Durable Medical Equipment ("DME") section of this *SPD*.
37. Health care professional services for maternity labor and delivery in the home.
38. Health club memberships.

39. Acupuncture, except when used in place of anesthesia and provided in connection with other *health care services* covered under this plan.
40. Recreational, *educational*, or self-help therapy or items primarily *educational* in nature or for vocation, comfort, convenience or recreation. Recreation therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.
41. Sexual dysfunction *prescription drugs*, unless otherwise covered in this *SPD* or approved for other use by an authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case reports.
42. Any weight loss programs and related services and/or drugs, except as otherwise covered as *preventive health care services.*
43. Private duty nursing, except as covered under this *SPD*.
44. Charges for *health care services*: (a) for which a charge would not have been made in the absence of health insurance; (b) for which *you* are not legally obligated to pay; and/or (c) from *providers* who waive any *coinsurance* or *deductible* that *you* are required to pay under this *SPD,* except as required under state or federal law.
45. Non-*emergency services* received outside the United States.
46. *Health care services* related to surrogate pregnancy for a person who is not a *covered person* under this *SPD*.
47. *Health care services* for gender reassignment, except when *medically necessary*.
48. Photographs, except for the condition of multiple dysplastic syndrome.
49. Coverage for costs associated with the translation of medical records and *claims* to English.
50. Repair of pierced body part and surgical repair of bald spots or loss of hair.
51. Services for or related to adoption and childbirth classes.
52. Services or *confinements* ordered by a court or law enforcement officer that are not *medically necessary*. Services that are not considered *medically necessary* include, but are not limited to, the following: custody evaluations, parenting assessment and /or competency, education classes for Driving Under the Influence (DUI) / Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, and domestic violence programs.
53. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer the therapy.
54. Services that do not involve direct patient contact such as delivery charges and recordkeeping.
55. Non-FDA approved use of medical marijuana, cannabis or tetrahydrocannabinol (THC).
56. Costs, charges, fees and other losses for non-*health care services*.
57. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing *educational* materials; updating patient information; requesting a *referral*; additional communication on the same day as an onsite medical office visit; or services that would similarly not be charged for in an onsite medical office visit; or telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.
58. *Biofeedback*, except for fecal/urinary incontinence.
59. Prolotherapy.
60. Platelet-rich plasma.
61. Coma stimulation/recovery programs.
62. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
63. Salivary Hormone Testing.
64. Reversal of voluntary sterilization.

The following exclusions are repeated from the "Benefit Schedule" section":

***For ease of reference, some exclusions may contain headings for categories of *health care services*. Please note that, except when applying exclusions to autism services, exclusions listed under any category of *health care services* shall apply to all *health care services*, regardless of the heading under which they are listed.**

65. Ambulance Services:
    a. See all exclusions.*
    b. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

66. Autism Services:
    a. Acupuncture, except when used in place of anesthesia and provided in connection with other *health care services* covered under this plan.
    b. Animal-based therapy including hippotherapy.
    c. Auditory integration training.
    d. Chelation therapy.
    e. Childcare fees.
    f. Cranial sacral therapy.
    g. Hyperbaric oxygen therapy.
    h. *Custodial care* or *respite care.*
    i. Special diets or supplements.
    j. *Provider* travel expenses.
    k. Therapy, treatment or services when provided to a *covered person* who is residing in a *residential treatment facility*, inpatient treatment or day treatment facility.
    l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of *your* home.
    m. Claims that have been determined to be fraudulent by the *Plan*.
    n. Treatment provided by parents or legal guardians who are otherwise qualified *providers*, supervising *providers*, therapists, professionals or paraprofessionals for treatment provided to their own children.

67. Chiropractic Services:
    a. See all exclusions.*
    b. *Maintenance care*.
    c. Blood, urine or hair analysis.
    d. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
    e. Manipulation under anesthesia.

68. Dental Services:
    a. See all exclusions.*
    b. Dental services covered under a separate dental plan offered by the same *Plan Sponsor* that offers this *SPD*.
    c. Preventive dental procedures.
    d. *Health care services* or dental services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as covered for accidental *injury*, *medically necessary* dental services and *hospital* facility fees and anesthesia covered under this "Dental Services" section of this *SPD*.
    e. Orthodontia and all associated expenses.
    f. Removal of a tooth root without the removal of the whole tooth.
    g. Root canal therapy, except when performed simultaneously with an apicoectomy.
    h. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay, except as covered under this "Dental Services" section of this *SPD*.
    i. Dental implants or other implant-related procedures.
    j. Prescriptions written by a *dentist* unless in connection with dental procedures covered by the *Plan*.
    k. *Health care services* or dental services related to periodontal disease, except as covered for *hospital* facility fees and anesthesia covered under this "Dental Services" section of this *SPD*.
    l. Occlusal adjustment or occlusal equilibration.
    m. Treatment of bruxism.

69. Durable Medical Equipment (DME), Services and Prosthetics:
    a. See all exclusions.*
    b. Any durable medical equipment or supplies not listed as eligible on the *TPA's* durable medical equipment list, or as determined by the *Plan Administrator*.
    c. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage. This exclusion does not apply to catheters, diabetic supplies or other medical supplies identified as eligible supplies in the Medical Policy on Durable Medical Equipment and Supplies which can be found on our member website at www.aspirushealthplan.com or by contacting Customer Service.
    d. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
    e. Repair or replacement of durable medical equipment and prosthetics less than three years after original purchase, except for insulin pumps and glucose monitors.
    f. Repair or replacement of insulin pumps or glucose monitors less than one year after original purchase.
    g. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
    h. Replacement of equipment unless we determine it is *medically necessary.*
    i. Replacement of over-the-counter batteries.
    j. Duplicate or similar items.
    k. Devices and computers to assist in communication and speech.
    l. Durable medical equipment that we determine to be for *your* comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
    m. Continuous passive motion (CPM) devices and mechanical stretching devices.
    n. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
    o. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
    p. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
    q. Over-the-counter orthotics and appliances.
    r. Orthopedic shoes, unless *you* have diabetes or peripheral vascular disease.
    s. Charges for sales tax, mailing and delivery.
    t. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
    u. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living*.
    v. Durable medical equipment, orthotics and prosthetics that we determine to have special features that are not *medically necessary.*
    w. Wigs, toupees, hairpieces, cranial prothesis, hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
    x. Upgrades to, or replacement of, any items considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
    y. Blood pressure cuffs and monitors.
    z. Enuresis alarms.
    aa. Trusses.
    bb. Ultrasonic nebulizers.
    cc. Oral appliances for snoring.
    dd. Penile prosthesis, except when impotence: (1) is caused by an organic function; (2) is a complication that is a direct result of a covered surgery; or (3) is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful.
    ee. Specialized prosthetics beyond the standard model, as determined by the *Plan Administrator*.

70. *Emergency Services*:
    a. See all exclusions.*
    b. Non-*emergency services* received in an emergency room.

71. *Hearing Aids, Implantable Hearing Devices* and Related Services:
    a. See all exclusions.*
    b. Hearing protection equipment.
    c. *Hearing aid* batteries and cords.
    d. Over-the-counter *hearing aids.*

72. *Home Care* Services:
    a. See all exclusions.*
    b. Companion and *home care* services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
    c. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
    d. *Health care services* and other services that can be performed by a non-medical person or self-administered.
    e. Home health aides, when care in the home by a home health aide is not the most medically appropriate place of service or the most medically appropriate *provider* for those *health care services*.
    f. *Health care services* and other services provided in *your* home for convenience, or due to lack of transportation.
    g. *Custodial care,* except home health aide services as covered in this section.
    h. *Health care services* and other services at any site other than *your* home.
    i. Recreational therapy.
    j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their homes.

73. Hospice Care:
    a. See all exclusions.*
    b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
    c. Respite or rest care, except as specifically described in this section.
    d. Room and board for residential care at a "hospital" facility.

74. *Hospital* Services:
    a. See all exclusions.*
    b. Travel, transportation, other than ambulance transportation, or living expenses.
    c. Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
    d. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
    e. Orthoptics and surgery for refractive conditions correctable by contacts or glasses, i.e., lasik surgery
    f. *Health care services* for gender reassignment, except when *medically necessary*.
    g. Genetic testing and associated *health care services*, except as covered under this *SPD.*
    h. Hypnosis.
    i. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
    j. Routine foot care, unless required due to diabetes or peripheral vascular disease.
    k. Autopsies.
    l. Services or items for personal convenience, such as television rental.
    m. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services.*
    n. Nutritional counseling, except as provided under the "Office Visits" and "*Preventive Health Care Services"* sections of this *SPD.*
    o. Marital counseling, relationship counseling, family counseling except as covered under this *SPD*, or other similar counseling or training services.
    p. Services to hold or confine a *covered person* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
    q. Counseling, studies, *confinements, health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator* except as covered under this "*Hospital* Services" section of this *SPD*.
    r. *Health care services* which are court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this *Plan*. This *Plan* does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.
    s. Cardiac rehabilitation beyond Phase II.

75. *Infertility* Services:
    a. See all exclusions.*
    b. Reversal of voluntary sterilization.
    c. Adoption costs.
    d. *Health care services* related to surrogate pregnancy for a person who is not a *covered person* under this *SPD*.
    e. Sperm, ova or embryo acquisition, retrieval or storage.

76. Office Visits:
    a. See all exclusions.*
    b. Health education, except when:
        1. Provided during an office visit for non-*preventive health care services*; or
        2. It is counseling that is treated as a *preventive health care service*.
    c. Any weight loss programs and related *health care services* that are not received from *participating providers*, or otherwise covered as *preventive health care services.*
    d. Nutritional counseling, except as provided under the "Office Visits" and "*Preventive Health Care Services"* sections of this *SPD.*
    e. Marital counseling, relationship counseling, family counseling, or other similar counseling or training services except as covered under this *SPD*.
    f. Professional sign language and foreign language interpreter services in a *provider's* office.
    g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
    h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by the *Plan Administrator*.
    i. Genetic testing and associated *health care services*, except as covered under this *SPD*.
    j. Hypnosis.
    k. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
    l. Routine foot care, unless required due to diabetes or peripheral vascular disease.
    m. Vision therapy/orthoptics.
    n. *Health care services* which are court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this *Plan*. This *Plan* does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

77. Organ and Bone Marrow *Transplant Services*:
    a. See all exclusions.*
    b. *Transplant services* received from a *provider* that is not a *designated transplant network provider.*
    c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
    d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary*.
    e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
    f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
    g. Treatment of medical complications to a donor after procurement of a transplanted organ if the donor is not a *covered person*.
    h. Computer search for donors.
    i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
    j. Travel expenses related to a covered transplant in excess of $5,000.
    k. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.
    l. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.

78. Physical Therapy, Occupational Therapy, Speech Therapy, Aquatic Therapy and Respiratory Therapy:
    a. See all exclusions.*
    b. *Custodial care* or *maintenance care*.
    c. Therapy provided in *your* home for convenience.
    d. Therapy for conditions that are self-correcting.
    e. Voice training and voice therapy absent a medical condition.
    f. *Investigative* therapies.
    g. Group therapy for physical therapy, occupational therapy and speech therapy.
    h. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
    i. *Health care services* for homeopathy and immunoaugmentive therapy.

79. *Prescription Drug* Services:
    a. See all exclusions.*
    b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
    c. Refill or replacement of a *prescription drug* or supply due to loss, damage, theft, spillage, spoilage or other actions that render it unusable.
    d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *SPD*.
    e. *Prescription drugs* that are equivalent to or similar to OTC drugs, except as provided in the drug *formulary*.
    f. OTC home testing products, except diabetic supplies, glucose monitors and blood and urine test strips for diabetes, or as otherwise required to be covered under federal law.
    g. Drugs not approved by the FDA, and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when the *Plan Administrator*, at its sole discretion, determines to include the drug on its *formulary* or approves coverage of the drug for the particular use.
    h. Take home drugs when dispensed by a *physician,* physician assistant or advanced practice registered nurse.
    i. Weight loss drugs.
    j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *SPD*.
    k. Drugs used for *cosmetic* purposes.
    l. Unit dose packaging.
    m. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use, but is being applied topically).
    n. *Prescription drugs* given or administered as part of a drug manufacturer's study.
    o. *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
    p. *Prescription drugs* for the treatment of sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to *you*.
    q. Off-label use of drugs determined to be *investigative*.
    r. Certain *combination drugs* and other drugs if they are listed as not covered on the *formular*y.
    s. *Compounded drugs* being used for bio-identical hormone replacement therapy, except as covered under this *SPD*.
    t. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition, or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *SPD.*
    u. Prescribed or non-prescribed vitamins or minerals including OTC, unless covered as *preventive health care services*.
    v. Medicinal foods, supplemental feedings, nutritional and electrolyte supplements, and infant formula, except when *medically necessary* or as otherwise covered under section VI.G. Durable Medical Equipment ("DME") Services, Prosthetics, and Orthotics.
    w. *Specialty drugs* obtained at any pharmacy other than our designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through our designated specialty pharmacy.
    x. Non-*formulary* drugs, unless an exception is obtained from the *Plan Administrator.*
    y. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *SPD,* except as required under state or federal law.

80. Preventive Contraceptive Methods and Counseling for Women:
    a. See all exclusions.*
    b. Contraceptives and related *health care services* received from *non-participating providers*.
    c. Sterilization procedures performed by *non-participating providers*.
    d. Abortions are not covered under this section of this *SPD*.
    e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
    f. Hysterectomies are not covered under this section of this *SPD*.
    g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures including, but not limited to, Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *SPD*.
    h. Reversal of sterilization procedures.
    i. Non-*preventive health care services* are not covered under this section of this *SPD*.

81. *Preventive Health Care Services*:
    a. See all exclusions.*
    b. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *SPD*.
    c. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
    d. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *SPD*.
    e. Non-prescribed over-the-counter medications.
    f. Travel immunizations.

82. *Reconstructive* Surgery:
    a. See all exclusions.*
    b. *Health care services* to treat conditions that are *cosmetic* in nature.

83. *Skilled Care* Services:
    a. See all exclusions.*
    b. Respite or *custodial care*.
    c. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. *home care* or care in an outpatient setting).
    d. Care that is available to *you* at no cost to *you* or care provided under a government health care program (other than a state Medicaid Plan or state CHIP).

VIII. Ending *Your* Coverage

Your coverage will terminate on the earliest of the following dates:

- The date the *Plan* is terminated;
- The end of the month in which the *covered employee* retires;
- The end of the month in which *your* eligibility under the *Plan* ends; however, a *covered employee*, who (a) is classified by the *Plan Sponsor* as a full-time employee for a stability period using the look-back measurement method (under the ACA and IRS) and (b) remains employed during the stability period, continues to be classified as a full-time employee during the stability period regardless of the number of hours worked during the stability period and, therefore, remains eligible for coverage during the stability period.
- The end of the month in which *your* written request to terminate coverage is received; unless the *covered employee's* premium payments are paid on a pre-tax basis, as pre-tax premium payments can only cease when certain change in status events occur;
- When *you* do not make/reimburse *your* required *contribution* to the Employer for coverage under the *Plan* by the end of the grace period. "Grace period" is defined as 60 days of coverage from the first day of the month in which the premiums in arrears initially fell into arrears.
- The date *you*, or someone acting on *your* behalf, performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*.
- The end of the month following the date *you* enter active military duty for more than 31 days. Upon completion of active military duty, contact the Employer for reinstatement of coverage.
- The date of the death of the *covered person*. In the event of the *covered employee's* death, coverage for the *covered employee's* dependents will terminate the end of the month in which the *covered employee's* death occurred.
- For a spouse, the end of the month following the date of divorce.
- For a stepchild, the end of the month in which the parent of the stepchild is no longer married to the *covered employee.*
- When the maximum period for coverage under COBRA Continuation Coverage expires for a *covered person*.
- For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
  a. The QMCSO ceases to be effective; or
  b. The child is no longer a child as that term is used in *ERISA*; or
  c. The child has immediate and comparable coverage under another plan; or
  d. The *covered employee* who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the Employer; or
  e. The Employer terminates family or dependent coverage; or
  f. The relevant premium or *contribution* toward the premium is last paid.

For a *covered dependent* child, coverage will terminate the end of the month in which the child is no longer eligible as a *covered dependent*. If *your covered dependent* child is disabled, coverage will end the end of the month in which the *covered dependent* child is no longer disabled.

If a *covered employee* is offered a severance package by the *employer*, the terms of that severance package will supersede the provisions stated here.

IX. Leaves of Absence

A. Family and Medical Leave Act (FMLA)

If *you* are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA) or an approved non-FMLA related medical leave, coverage may be continued for the duration of the approved leave of absence, not to exceed 13 weeks, as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date *you* notify the employer that *you* do not intend to return to work. *You* are responsible for all required *contributions*.

If *you* do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that *you* elect to continue under that provision. If *you* return to work immediately following *your* approved FMLA leave, no new *waiting periods* will apply.

FMLA applies to employees of a covered employer that work at a worksite within 75 miles of where that employer employs at least 50 employees.

B. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of *Benefits*. *Covered employees* who are absent for leaves greater than 30 days due to service in the uniformed services and/or their covered *dependents* may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

This continuation of coverage pursuant to USERRA runs concurrent with COBRA for as long as you continue to qualify under both USERRA and COBRA. If USERRA coverage terminates prior to the date that *your* COBRA coverage would terminate, *your* COBRA coverage will continue as provided under "Section X – COBRA Continuation Coverage" of this *SPD.*

Eligibility. A *covered employee* is eligible for continuation under USERRA if the *covered employee* is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered dependents who have coverage under this *SPD* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following the *covered employee's* leave under USERRA, no new *waiting periods* will apply.

Premium Payment. If continuation of *Plan* coverage is elected under USERRA, the *covered employee* or *covered dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount that the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost is 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the employer.

Duration of Coverage. Elected continuation of coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;
2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;
3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or
4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." *Covered employees* should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage, and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period.
2. Thirty-one to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.
3. One hundred and eighty-one days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.
4. Service-connected *injury* or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

Coverage Following Return to Work. If a *subscriber's* coverage ends due to a military leave absence of greater than 30 days, upon return to active employment, employee will be able to enroll in the Plan. Coverage shall be effective upon enrollment, with no waiting period.

C. Other Leaves of Absence

If *you* are absent from work due to an approved personal, non-medical leave of absence, coverage may be continued for up to 30 days following the date on which your approved leave of absence begins or until *you* notify the employer that *you* do not intend to return to work. *You* are responsible for all required *contributions.*

If *you* do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that *you* elect to continue under that provision. If *you* return to work immediately following *your* approved medical leave, no new *waiting periods* will apply.

X. COBRA Continuation Coverage

Note: This section runs concurrent with any applicable retiree coverage.

The *covered employee*, the covered spouse and covered dependent children may continue coverage under the *Plan* when a qualifying event occurs. *You* may elect COBRA for *yourself* regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the *covered employee* may continue coverage and may also continue coverage for the *covered employee's* covered spouse and covered dependent children when coverage would normally end;
2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end;
3. Coverage will be the same as that for other similar *covered persons*; and
4. Continuation coverage under this *Plan* ends when this *Plan* terminates or as explained in detail on the following Continuation Chart. The *covered employee*, the covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. *You* should contact the Employer for details about other continuation coverage.

For additional information about *your* rights and obligations under the *Plan* and/or federal COBRA law, *you* should contact the Employer, which is the official *Plan Administrator*.

Qualifying Events

1. Loss of coverage under the *Plan* by the *covered employe*e due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.
2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.
   f. *Covered employee* becoming enrolled in Medicare.
   g. Divorce or legal separation of the *covered employee*.
   h. Death of the *covered employee*.
3. Loss of coverage under this *Plan* by the covered dependent child due to loss of "dependent child" status under the *Plan*.
4. Loss of coverage under this *Plan* due to the bankruptcy of the employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. This provision applies to the covered retiree, the covered spouse and covered dependent children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, or the bankruptcy of the Employer, the *Plan Administrator* will offer continuation coverage to qualified *covered persons*. *You* do not need to notify the *Plan Administrator* of these qualifying events. However, for other qualifying events including divorce or legal separation of the *covered employee* and loss of dependent child status, COBRA continuation is not available to *you* if *you* do not provide timely, written notice to the *Plan Administrator* as required below by the *Plan*. *You* must also provide timely, written notice to the *Plan Administrator* of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the *Plan* as stated in this section. To elect COBRA, *you* must make a timely, written election as required by the *Plan* as stated in this section.

What the *Plan Administrator* must do:

1. Provide initial general COBRA notices as required by law;
2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;
3. Notify persons of the unavailability of COBRA continuation;
4. Notify the *covered person* of the *covered person's* rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered spouse and/or covered dependent children;
5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and
6. Notify the *covered person* when the *covered person* is no longer entitled to COBRA or when the *covered person's* COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What *You* must do:

1. *You* must notify the *Plan Administrator* in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;
2. *You* must notify the *Plan Administrator* in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;
3. *You* must submit *your* notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the *Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents;
   - The description and date of the qualifying event;
   - Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and
   - The name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

All written notices as described previously in paragraphs 1, 2, and 3, under "What *You* must do" must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

1. To elect continuation, *you* must notify the *Plan Administrator* of *your* election in writing within 60 calendar days after the date the *covered person's* coverage ends, or the date the *covered person* is notified of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Plan's* approved election form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This election must be submitted to the *Plan Administrator* in writing at the address as described in this section; and

2. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The continuation election form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

What *you* must do to apply for COBRA extension:

A. Social Security Disability:

1. If *you* are currently enrolled in COBRA continuation under this *Plan*, and it is determined that *you* are totally disabled by the Social Security Administration within the first 60 calendar days of *your* current COBRA coverage, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing of the Social Security Administration's determination within 60 calendar days after the latest of:
   - The date of the Social Security Administration's disability determination;
   - The date of the *covered employee's* termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
   - The date on which *you* would lose coverage under the *Plan* as a result of the *covered employee's* termination, reduction of hours, leave of absence, retirement, or layoff.

2. *You* must submit *your* written notice of total disability within the 60 day timeframe, as described previously in paragraph 1, and before the end of the 18th month of *your* initial COBRA coverage using the *Plan's* approved disability notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted, in writing, to the *Plan Administrator* and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The name of the disabled *covered person*;
   - The date the *covered person* became disabled;
   - The date the Social Security Administration made its determination of disability;
   - Requested copy of the Social Security Administration's determination of disability; and
   - The name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a Social Security disability extension must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the Social Security Administration's determination, in writing, within the 60 calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The disability notice form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

B. Second Qualifying Events for *Covered Dependent*s Only:

1. If *you* are currently enrolled in COBRA continuation under this *Plan* and the *covered employee* dies, or in the case of divorce or a legal separation of the *covered employee*, or a covered dependent child loses eligibility, then *you*

may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct or resulted from a Social Security Administration disability determination. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing within 60 calendar days after the later of:

- The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
- The date on which the *covered dependent*(s) would lose coverage as a result of the second qualifying event.

Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a *covered employee* becomes entitled to Medicare.

2. *You* must submit *your* written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the *Plan's* approved second event notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* in writing and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The description and date of the second qualifying event;
   - Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
   - The name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a second qualifying event extension must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan.*"

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the second qualifying event in writing within the 60 calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The election form will set forth *your* continuation premium *contribution* rates.
   b. The first premium *contribution* must be paid within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

Additional Notices *You* Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) *your* other group coverage that begins after COBRA is elected under the *Plan*; (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the *Plan*; and (3) the *covered person*, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the *Plan's* approved notification form within 30 calendar days of the events requiring additional notices as previously described**. The notification form can be obtained from the *Plan Administrator* and must be completed by *you* and timely submitted to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan.*"** In addition to providing all required information requested on the *Plan's* approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the *covered person* who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the *covered person* that became entitled to Medicare, and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled *covered person*, the date that the Social Security Administration determined that the *covered person* was no longer disabled, and a copy of the Social Security Administration's determination.

If *you* do not provide this required additional notice, *you* must reimburse any claims mistakenly paid for expenses *incurred* after the following applicable date:

- *Your* other group coverage begins;
- *Your* Medicare Part A or Part B enrollment begins; or
- *Your* disability ends.

CONTINUATION CHART

If coverage under this *Plan* is lost because this happens…	**Who is eligible to continue…**	**Coverage may be continued until the earliest of**: a) the date coverage would otherwise end under the *Plan*; or b) the end of the month in which the earliest of the following applicable events occurs:
The *covered employee's* leave of absence, early retirement, hours were reduced, layoff, or the *covered employee's* employment with the Employer ended for reasons other than gross misconduct.	*Covered employee*, covered spouse and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Death of the *covered employee*. Divorce or legal separation from the *covered employee*. Entitlement of the *covered employee* to Medicare within 18 months before the *covered employee's* hours were reduced or termination of employment for reasons other than gross misconduct. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered spouse and covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of *covered employee* to Medicare but only for an event which is the *covered employee's* Medicare entitlement within 18 months before the *covered employee's* hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered dependent child	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered retiree, covered spouse and covered dependent children	• Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered spouse and covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the *Plan*.
The *covered employee*, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the *covered employee's* leave of absence, early retirement, reduction in hours, layoff, or the *covered employee's* termination of employment with the Employer for reasons other than gross misconduct. Timely notice of such disability must be provided by the *covered person* in accordance with the *Plan's* notice procedures previously described for COBRA extensions due to Social Security disability.	*Covered employee*, covered spouse and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that *covered employee*, covered spouse or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.

Special Enrollment Periods

If *you* are a *covered employee*, covered spouse, or *covered dependent* who is enrolled in continuation coverage under this *Plan* due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this *SPD* as referenced in the section which describes eligibility and enrollment will apply to *you* during the continuation period required by federal law as such provisions would apply to an active eligible *covered employee*. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a *covered employee* during such *covered employee's* continuation period required by federal law, and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and *you* are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, *you* may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents.

USERRA and COBRA

For members that qualify for both COBRA continuation coverage and USERRA, COBRA continuation coverage runs concurrent with USERRA for as long as you continue to qualify under both COBRA and USERRA. If COBRA coverage terminates prior to the date that *your* USERRA coverage would terminate, *your* USERRA coverage will continue as provided under "Section IX. B.– The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)" of this *SPD.*

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

Federal trade act laws give special COBRA rights to *covered employees* who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under federal laws, including the Trade Adjustment Assistance Reauthorization Act of 2015.

If *you* qualify or may qualify for trade adjustment assistance, contact the *Plan Administrator* for additional information. *You* must contact the *Plan Administrator* promptly after qualifying for trade adjustment assistance or *you* will lose *your* special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections, and information required to be furnished or submitted by a *covered person*, covered spouse or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements, and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the *Plan*.

XI. Subrogation and Reimbursement

Subrogation

The *Plan* and the *Plan Administrator* have the full and unrestricted right of subrogation with respect to any *sickness* or *injury* for which any *benefit* or payment is provided, or may at any time in the future be provided, under the *Plan*. The *Plan Administrator* has delegated to the *TPA* the ability to pursue this right, and the authority to redelegate such activity to other individuals or entities. That right of subrogation also extends to any coverage or rights a *covered person* has, or may have, under any insurance coverage, including, but not limited to, any no fault insurance, uninsured or underinsured motorist coverage. The *Plan's* and the *Plan Administrator's* right of subrogation shall in all circumstances fully apply without limitation and shall not be reduced under any circumstances, even if a *covered person* is not made whole for damages or losses, such as damages for pain and suffering, lost wages, etc.

The *Plan's* and the *Plan Administrator's* subrogation rights shall also not be reduced by any expenses *incurred* by any *covered person*, including, but not limited to, attorneys' fees. Any and all amounts recovered by or on behalf of a *covered person* by settlement, judgment, arbitration or by any means whatsoever shall be placed into a constructive trust subject to the *Plan's* and the *Plan Administrator's* right of subrogation or shall be paid over to the *Plan* without any reduction, regardless of how such amounts are characterized or allocated. The *Plan's* and the *Plan Administrator's* subrogation rights shall have priority over any rights or *claims* of a *covered person*, and pursuant to such right of priority, the *Plan* shall first be paid in full for its subrogation rights before any amount, regardless of how characterized or allocated, is retained by, or for, a *covered person*.

A *covered person* shall fully cooperate with the *Plan*, the *Plan Administrator*, the *TPA* and their designees in the enforcement of the *Plan's* and the *Plan Administrator's* subrogation rights, which cooperation shall include, but not be limited to, paying over to the *Plan* any and all amounts due the *Plan* and the execution of any agreements, assignments or other instruments requested by the *Plan*, the *Plan Administrator*, the *TPA* and their designees. If information and assistance are not provided to the *Plan* upon request, no *benefits* will be payable under the *Plan* with respect to costs *incurred* in connection with such *sickness* or *injury*. If the *sickness* or *injury* giving rise to subrogation involves a minor child or wrongful death of a *covered person*, this provision applies to the parents or guardian of the minor *covered person* and the personal representative of the deceased *covered person*. A *covered person* shall take no action which directly or indirectly adversely affects the *Plan's* and the *Plan Administrator's* rights of subrogation, and any settlement entered into by or on behalf of a *covered person* shall be subject to and shall fully recognize the *Plan's* and the *Plan Administrator's* right of priority to be fully repaid for its subrogation rights from any and all amounts, regardless of how characterized or allocated, recovered in connection with such settlement before any amounts from such settlement are retained by, or for, a *covered person*.

As a condition of receiving *benefits* under this *Plan*, *you* agree:

- To reimburse the *Plan* for any such *benefits* paid or payable to, or on behalf of, the *covered person* when said *benefits* are recovered from any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, medical payment provision or other insurance policies or funds.
- The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive, final and binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Plan Administrator* has expressly delegated to other persons or entities one or more fiduciary responsibilities with respect to the *Plan*. The rights of subrogation and reimbursement shall bind the *covered person's* guardian(s), estate, executor, personal representative and heir(s).

Reimbursement Rights

You agree to hold in constructive trust the proceeds of any settlement or judgment for the *Plan's* and the *Plan Administrator's benefit* under this Section. If *you* fail to reimburse the *Plan* out of any recovery or reimbursement received for all *benefits* paid or to be paid as a result of *your sickness* or *injury*, *you* will be liable for any and all expenses, whether fees or costs, associated with the *Plan's*, the *Plan Administrator's*, the *TPA's* and their designees' attempts to recover such money from *you*.

XII. Coordination of *Benefits*

As a *covered person*, *you* agree to permit the *Plan* to coordinate obligations under this *SPD* with payments under any other health *benefit* plans as specified below, which covers *you* as an employee or dependent. *You* also agree to provide any information or submit any *claims* to other health *benefit* plans necessary for this purpose. *You* agree to authorize billing to other health plans for purposes of coordination of *benefits*.

Unless applicable law prevents disclosure of the information without the consent of the *covered person* or the *covered person's* representative, each *covered person* claiming *benefits* under this *Plan* must provide any fact needed to pay the *claim*. If the information cannot be disclosed without consent, the *Plan* will not pay *benefits* until the information is given.

A. Application. This Coordination of *Benefits* provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

The order of *benefit* determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan might cover some expenses. A secondary plan pays after the primary plan and may reduce the *benefits* it pays so that payments from all plans do not exceed 100% of the total allowable expense.

B. Definitions. These definitions only apply to the Coordination of *Benefits* provision.

Allowable Expenses. Means *health care services* or expenses, including *deductibles, coinsurance* and copayments that are covered at least in part by any of the plans covering the person. When a plan provides *benefits* in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a *benefit* paid. An expense or service that is not covered by any of the plans is not an allowable expense.

***Claim* Determination Period.** Means a *calendar year*. However, it does not include any part of a year during which *you* have no coverage under this *Plan*, or before the date this Coordination of *Benefits* provision or a similar provision takes effect.

Closed Panel Plan. Means a plan that provides health *benefits* to persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan, and that limits or excludes *benefits* or services provided by other *providers*, except in cases of *emergency* or *referral* by a panel *covered person*.

Custodial Parent. Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the *calendar year* without regard to any temporary visitation.

Plan. Means any of the following that provides *benefits* or services for medical or dental care or treatment. However, if separate policies are used to provide coordinated coverage for members of any group, the separate policies are considered parts of the same plan and there is no Coordination of Benefits among these policies.

1. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured);
2. *Hospital* indemnity *benefits* in excess of $200 per day;
3. Medical care components of group long-term care policies, such as *skilled care*;
4. A labor-management trustee plan or a union welfare plan;
5. An employer or multi-employer plan or employee *benefit* plan;
6. Medicare or other governmental *benefits*, as permitted by law;
7. Insurance required or provided by statute;
8. Medical *benefits* under group or individual automobile policies;
9. Individual or family insurance for *hospital* or medical treatment or expenses;
10. Closed panel or other individual coverage for *hospital* or medical treatment or expenses.

Plan does not include any:

1. Amounts of hospital indemnity insurance of $200 or less per day;
2. Benefits for non-medical components of group long-term care policies;
3. School accident-type coverages;
4. Medicare supplement policies;
5. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The *benefits* provided by a plan include those that would have been provided if a *claim* had been duly made.

Primary Plan/Secondary Plan. Means the order of *benefit* determination rules which determine whether this plan is a "primary plan" or "secondary plan," when compared to the other plan covering the person.

When this *Plan* is primary, its *benefits* are determined before those of any other plan and without considering any other plan's *benefits*. When this *Plan* is secondary, its *benefits* are determined after those of another plan and may be reduced because of the primary plan's *benefits*.

C. Order of Benefit Determination Rules: The primary plan pays or provides its *benefits* as if the secondary plan or plans did not exist. The order of *benefit* determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the *benefits* it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of *Benefits* provision that is consistent with this section is always primary. **Exception**: Group coverage designed to supplement a part of a basic package of *benefits* may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the employer.

A plan may consider the *benefits* paid or provided by another plan in determining its *benefits* only when it is secondary to that other plan.

This *Plan* will not pay more than it would have paid had it been the primary plan. This *Plan* determines its order of *benefits* by using the first of the following that applies:

1. **Nondependent/Dependent:** The plan that covers the person other than a dependent, for example as an employee, subscriber, or retiree, is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as a nondependent (e.g., a retired employee);

   then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary. The determination of primary and secondary payor when the other coverage is Medicare is based on Medicare status and regulations.

2. **Child Covered Under More Than One Plan**: The order of *benefits* when a child is covered by more than one plan is:

   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of *benefits* is the plan of the:
      - Custodial parent;
      - Spouse of the custodial parent;
      - Noncustodial parent; and then
      - Spouse of the noncustodial parent.
   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of *benefits* shall be determined under paragraph 2.a of this section as if those persons were parents of such child.
   e. For a dependent child who has coverage under either or both parents' plans and who also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of *benefits* shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent's spouse.

3. **Active/Inactive Employee**: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that

employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of *benefits*; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of *benefits*. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
   a. The plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan.
   b. The continuation coverage is the secondary plan.

   If the other plan does not have this rule in paragraph 4; and if, as a result, the plans do not agree on the order of *benefits*; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of *benefits*.

5. **Longer/Shorter Length of Coverage**: If none of the above rules determines the order of *benefits*, the benefits of the *plan* which covered an employee, dependent or retiree longer are determined before those of the *plan* which covered that person for the shorter time.

D. **The Effect on the *Benefits* of this *Plan*:** When this *Plan* is secondary, it may reduce its *benefits* at the time of processing, so that the total *benefits* paid or provided by all plans for each *claim* are not more than 100% of total allowable expenses for such *claim*. The reduction in this *Plan's benefits* is equal to the difference between:

1. The *benefit* payments that this *Plan* would have paid had it been the primary plan; and
2. The *benefit* payments that this *Plan* actually paid or provided.

When the *benefits* of this *Plan* are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as a visit limit under this *Plan*.

E. **Right to Receive and Release Information**: Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine *benefits* payable under this *Plan* and other plans. The *TPA* may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining *benefits* payable under this *Plan* and other plans covering the person claiming *benefits*. The *TPA* need not tell, or get the consent of, any person to do this. Each person claiming *benefits* under this *Plan* must give the *Plan* any facts it needs to apply those rules and determine *benefits* payable.

F. **Facility of Payment**: A payment made under another plan may have included an amount that should have been paid under this *Plan*. If it does, the *Plan* may pay that amount to the organization that made the payment. That amount will then be treated as though it was a *benefit* paid under this *Plan*. The *Plan* will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services. In this case "payment made" means the reasonable cash value of the *benefits* provided in the form of services.

G. **Right of Recovery**: If the *Plan* paid more than it should have paid, it may recover the excess from one or more of the following:

1. The persons the *Plan* has paid or for whom it has paid; or
2. Any other person or organization that may be responsible for the *benefits* or services provided under this *Plan* to the *covered person*.

The "amount of payments made" includes the reasonable cash value of any *benefits* provided in the form of services.

H. **Coordinating with Medicare:** If a *provider* has accepted assignment of Medicare, this *Plan* determines allowable expenses based upon the amount allowed by Medicare. This *Plan's* allowable expenses for a *participating provider* is the lesser of (1) the amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* or (2) the Medicare allowable amount. This *Plan's* allowable expenses for a *non-participating provider* is the lesser of (1) the *usual and customary amount* or (2) the Medicare allowable amount. This *Plan* pays the difference between what Medicare pays and the *Plan's* allowable expenses.

Renal Failure. If *you* begin to have services related to renal failure, we request that *you* sign up for Medicare.

For a c*overed person* with End-Stage Renal Disease (ESRD), this *Plan* usually has primary responsibility for the claims of a c*overed person* for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

XIII. How to Submit a Bill if *You* Receive One for *Covered Services*

Timely Payment of *Claims.* *Post-service claims* for *benefits* will be paid promptly upon receipt of an itemized bill and written proof of loss. All or any portion of any *benefits* provided by the *Plan* may be paid directly to the *provider* rendering the services. Payment will be made according to our coverage guidelines.

Payment of *Claims.* All or any portion of any *benefits* provided to *you* or on *your* behalf for *hospital*, nursing, medical or surgical services may, at the *Plan's* option, be paid directly to the *hospital* or *provider* providing such services.

At the *Plan's* option, all payments for *claims* may be made directly to the *provider* of medical services, the custodial parent or Wisconsin Department of Human Services rather than to the *covered employee*, for *claims incurred* by a child who is covered as a dependent of a *covered employee* who has legal responsibility for the dependent's medical care pursuant to a court order, provided we are informed of such order. This payment will discharge us from all further liability to the extent of the payment made. If the *covered person* who receives such services is deceased at the time of payment, the *Plan* may at our option pay the *provider* of medical services or the *covered person's* estate.

A. Bills from *Participating Providers*

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of *post-service claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit *claims* on *your* behalf. If *you* receive an invoice or bill from *your provider* for services, simply return the bill or invoice to *your provider*, noting *your* enrollment in the *Plan*. *Your provider* will then submit the *post-service claim* under the *Plan* in accordance with the terms of its participation agreement. *Your claim* will be processed for payment according to the Employer's coverage guidelines. The *TPA* must receive *claims* within 365 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. *Claims* received after the deadline will be denied.

B. Bills from *Non-Participating Providers*

***Claim* Submission**. *You* must submit a completed *claim* form in writing, together with an itemized bill for the services *incurred*, on the *claim* form provided and in accordance with the filing procedures for *post-service claims* outlined in the next section. The *TPA* must receive *claims* within 365 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. If the *Plan* is discontinued, the deadline for the receipt of *claims* is 180 calendar days. *Claims* received after the deadline will be denied. If *you* need *claim* forms, please contact Customer Service.

Payment of *Claims*. *Claims* for *benefits* will be paid promptly upon receipt of written proof of loss. *Benefits* which are payable periodically during a period of continuing loss will be paid on a periodic basis. All or any portion of any *benefits* provided by the *Plan* may be paid directly to the *provider* rendering the services. Payment will be made according to the Employer's coverage guidelines.

XIV. Initial Benefit Determinations of *Post-Service Claims*

Post-service *claims* are *claims* that are filed for payment of *benefits* under the *Plan* after *health care services* have been received and submitted in accordance with the *post-service claim* filing procedures for the *Plan*.

Filing Procedure for Post-Service *Claims*. To file a *post-service claim*, *you* or *your* attending *provider* must submit an itemized bill in writing and in accordance with the procedures and within the deadlines described in the section entitled "How to Submit a Bill if *You* Receive One for *Covered Services*." To be considered a properly filed *post-service claim* under the *Plan*, *your* completed *claim* form, together with an itemized bill and the essential data elements, must be submitted in writing to Customer Service at the mailing address noted inside the cover page to this *SPD*. *Your post-service claim* must include at least the following essential data elements:

- The identity of the *covered person* and *provider* of services;
- The date(s) of services;
- A specific medical diagnosis; and
- Specific treatment, *health care service* or procedure codes for which *benefit*s or payment is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling Customer Service. If *you* or *your* attending *provider* have not submitted the *post-service claim* in accordance with these filing procedures, including a failure to submit all essential data elements, *your post-service claim* will be treated as incorrectly filed. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives a written *post-service claim* submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* files a *post-service claim* on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such *claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry that is not made in accordance with the *Plan's claim* procedures will not be treated as a *claim* under the *Plan*.

Initial *Benefit* Determination. If *your post-service claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a *post-service claim* submitted in accordance with the *Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial *benefit* determination, it may extend the time period for the initial *benefit* determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 30 calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial *benefit* determination within 15 calendar days after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. If *you* and *your* authorized representative then submit the requested information within 365 calendar days after the date services were *incurred* (except in the absence of *your* legal capacity), the *Plan Administrator* may, but is not required to, reconsider the submitted information, and will not consider information it receives more than 365 calendar days after the date *your* services were *incurred*.

The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA's* control.

If *your post-service claim* is denied, notification will be provided to *you*. This notice will explain:

- Information sufficient to identify the *claim* involved and any information required by law.
- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals and Prior Authorization Appeals Processes" for details on requesting an appeal or external review.

XV. *Claim* Appeals and Prior Authorization Appeals Processes

Internal Appeals Process

The internal review process for an appeal of a *claim* that is wholly or partially denied and for a rescission (retroactive termination) of *your* coverage, as defined by the *Affordable Care Act*, is:

1. **Acute Care Services Appeals**

   If *your* request for prior authorization of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to the *TPA* in writing, by telephone, or electronically, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* appeal to the *Plan Administrator* for its decision.

   As quickly as *your* medical condition requires, but no later than 72 hours of receipt of *your* appeal by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended subject to applicable law, in which case we will provide *you* notice within the initial 15-day period.

2. **Non-Acute Care Services Appeals**

   a. **First Appeal**. If *your* request for prior authorization of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate.

Within 15 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it, references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended subject to applicable law, in which case we will provide you notice within the initial 15-day period.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 15 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended subject to applicable law, in which case we will provide you notice within the initial 15-day period.

3. **Concurrent Care *Claims***

If *your* concurrent care *claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to the *TPA* on the same basis as described above. Acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as acute care services appeals above. Non-acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as non-acute care services appeals above.

4. **Post-Service Appeals**

a. **First Appeal**. If *your post-service claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal within 180 calendar days after receiving notice that *your claim* is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information as appropriate.

Within 30 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 30 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

5. **Access to Relevant Documents**

Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your* appeal. If the *Plan Administrator* or the *TPA* generates, relies upon, or considers any new or additional evidence in connection with an appeal, or identifies any new or additional rationale for a denial in connection with an appeal, it will be provided to *you* so that *you* have a reasonable opportunity to respond. *You* have the right to present written evidence and testimony as part of the appeals process.

External Review Process for *Post-Service Claims*

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act*, or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*, *you* may have a right to have such decision reviewed by an *independent review organization* that is not associated with the *TPA*, *Plan* or *Plan Administrator*. The decision of the *independent review organization* is binding except to the extent other remedies may be available to the *Plan*, any person, or any entity under state or federal law. The following sections relating to Standard External Review and Expedited External Review apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act* or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*:

1. **Standard External Review**. *You* may request an external review of any pre-service request or *post-service claim* based on medical judgment if *you* have exhausted all appeals available to *you* under the internal appeals process. Any denial,

reduction, or termination of, or failure to provide payment for, a *benefit* based on a determination that *you* failed to meet the requirements for eligibility under the terms of the *Plan* is not eligible for external review. Within four months after receiving a notice informing *you* of *your* right to an external review by an *independent review organization*, *you* or *your* authorized representative may submit a written request for an external review with an *independent review organization* by sending it to the *TPA*. When *you* request an external review, *you* will be required to authorize release of any medical records that the *independent review organization* might need to review for the purpose of reaching a decision.

Within one business day after completion of a preliminary review, which may take up to five business days, to confirm whether *you* were enrolled properly in the *Plan* at the time the pre-service request was requested or *post-service claim* was provided, the *TPA* will notify *you* that *your* request is:

a. Complete and eligible for external review; or
b. Not complete, and will indicate what additional information or materials are needed to make it complete; or
c. Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for external review, the *TPA* will notify *you* which *independent review organization* will conduct the external review. *You* will then receive more detailed information, including contact information for the *independent review organization* and the independent review process and timetable.

2. **Expedited External Review**. *You* may request an expedited external review if:

a. *Your* request for prior authorization of acute care services is wholly or partially denied and *you* have not received such services, or *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, and the timeframe for completion of an expedited internal appeal would seriously jeopardize *your* life, health, or ability to regain maximum function. Nevertheless, *you* must have filed a request for an expedited internal appeal in order to request an expedited external review; or
b. *You* exhausted the internal appeals process and *you* have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize *your* life, health, or ability to regain maximum function; or
c. *You* exhausted the internal appeals process for coverage that involves an admission, availability of care, continued stay or health care item or service for which *you* received *emergency services* but have not been discharged from a facility.

When *you* request an external review, *you* will be required to authorize release of any medical records that the *independent review organization* might need to review for the purpose of reaching a decision. Immediately upon receipt of *your* request for an expedited external review, the *TPA* will make a determination and notify *you* that *your* request is:

- Complete and eligible for external review; or
- Not complete, and will indicate what information or materials are needed to make it complete; or
- Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for the external review process, the *TPA* will notify *you* which *independent review organization* will conduct the external review. *You* will then receive more detailed information, including contact information for the *independent review organization* and the independent review process and timetable.

A *covered person* who is not satisfied with the outcome of the independent external review has the right to request a final appeal for review and reconsideration directly from the Plan Sponsor.

XVI. If *You* Have a Complaint

If the complaint involves issues relating to quality of health care rendered by a *participating provider*, *you* should also attempt to discuss the quality of care issues with the *provider*. *You* may also direct any questions or complaints to Customer Service. When Customer Service is contacted, the representative will assist *you* in trying to resolve the complaint with the *provider* on an informal basis. The representative will also document the complaint. If these discussions are not satisfactory, *you* may submit a written complaint to the *Plan Administrator*. However, the *Plan* is not responsible for the quality of care rendered by a *participating provider*.

XVII. No Guarantee of Employment or Overall *Benefits*

The adoption and maintenance of this *Plan* does not guarantee or represent that the *Plan* will continue indefinitely with respect to any class of employees and shall not be deemed to be a contract of employment between the Employer and any *covered employee*. Nothing contained herein shall give any *covered employee* the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any *covered employee*, at any time, nor shall it give the

Employer the right to require any *covered employee* to remain in its employ or to interfere with the *covered employee's* right to terminate employment at any time not inconsistent with any applicable employment contract. Nothing in this *Plan* shall be construed to extend *benefit*s for the lifetime of any *covered person* or to extend *benefits* beyond the date upon which they would otherwise end in accordance with the provisions of the *Plan* or any *benefit* description.

XVIII. Definitions

Activities of Daily Living	*Eating*, *toileting*, *transferring*, *bathing*, *dressing*, walking, and *continence*.
Acute Care Facility	A facility that provides care to *you* when *you* are in the acute phase of a *sickness* or *injury* and will probably have a stay of less than 30 calendar days.
Affordable Care Act	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
Ancillary Services	Subject to changes made by the U.S. Department of Health and Human Services, ancillary services are, with respect to a *hospital* or ambulatory surgical center, which is a *participating provider*: 1. *health care services* related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a *physician* or non-*physician* practitioner, and *health care services* provided by assistant surgeons, hospitalists, and intensivists; 2. diagnostic services (including radiology and laboratory services);and 3. *health care services* provided by a *non-participating provider* if there is no *participating provider* who can furnish such *health care services* at such *hospital* or ambulatory surgical center.
Aspirus Health Plan	*Aspirus Health Plan, Inc.*, which is a *third party administrator* (*TPA*) providing administrative services to *your* Employer in connection with the operation of the *Plan*.
Attending Health Care Professional	The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to *you*. *Attending health care professional* shall include only *physicians*; chiropractors; *dentists*; mental health professionals; podiatrists; physician assistants; and advanced practice nurses.
Bariatric Surgery	Surgery and related expenses for the treatment of obesity.
Bathing	Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
Benefits	The *health care services* covered under the *Plan* as approved by the *Plan Administrator* as *covered services*, as explained in this *SPD* and any amendments.
Biofeedback	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
Bone Anchored Hearing Aid	A surgically implantable system for treatment of hearing loss that works through direct bone conduction.
Calendar Year	The 12-month period beginning January 1 and ending the following December 31.
Claim	A request for *benefit*s made by a *covered person* or the *covered person's* authorized representative in accordance with the procedures described in this *SPD*.

Clinical Trial

A phase I, phase II, phase III, or phase IV *clinical trial* that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. National Institutes of Health.
   b. Centers for Disease Control and Prevention.
   c. Agency for Health Care Research and Quality.
   d. Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in paragraphs a through d above or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Cochlear Implant

An implantable instrument or device that is designed to enhance hearing.

Coinsurance

A portion of *eligible charges* that is paid by *you* and a separate portion that is paid by the *Plan* for *covered services* and supplies. *Your coinsurance* is a percentage of those *eligible charges* that are the 1) discounted charges that are negotiated with the *participating provider* and calculated at the time the *claim* is processed; 2) the *usual and customary amount*, or 3) the amount *you* must pay after satisfying *your deductible* for *emergency services* provided by a *non-participating provider.*

Combination Drugs

A *prescription drug* in which two or more chemical entities are combined into one commercially available dosage form.

Compounded Drugs

Customized medications prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a *physician's* specifications to meet *your* needs.

Comprehensive Postnatal Visit

A visit with a health care *provider* that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Concurrent Care Decision

A decision by us to reduce or terminate *benefits* otherwise payable for a course of treatment that has been approved by us or a decision with respect to a request by *you* to extend a course of treatment beyond the period of time or number of treatments that has been approved by us.

Confinement

An uninterrupted stay of 24 hours or more in a *hospital, skilled nursing facility*, rehabilitation facility, or licensed *residential treatment facility.*

Continence	Ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.
Continuing Care Patient	*Continuing care patient* means a *covered person* who is: 1. Undergoing a course of treatment for a *serious and complex condition* from a *participating provider*; 2. Undergoing a course of institutional or inpatient care from a *participating provider*; 3. Scheduled to undergo nonelective surgery from a *participating provider*, including receipt of postoperative care from such *participating provider* with respect to such a surgery; 4. Pregnant and undergoing a course of treatment for the pregnancy from *participating provider*; or 5. Was determined to be terminally ill (i.e. *you* have received a medical prognosis that *your* life expectancy is 6 months or less) and is receiving treatment for such illness from *participating provider*.
Contribution	The payment *your* Employer requires to be paid on behalf of or for *covered persons* for the provision of *covered services*. *Your* Employer will inform *you* of *your* share, if any, of the *contribution* that must be paid or reimbursed by *you* to the Employer.
Convenience Care Center	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
Cosmetic	Services and procedures that improve physical appearance but do not correct or improve a physiological function and are not *medically necessary*.
Covered Dependent	A *covered employee's* eligible spouse or child(ren) as described in the "Eligibility, Enrollment, and *Effective Date*" section who is enrolled under the *Plan*.
Covered Employee	The person: 1. On whose behalf *contribution* is paid; and 2. Whose employment is the basis for membership; and Who is enrolled under the *Plan*.
Covered Person	A *covered employee* or *covered dependent*.
Covered Services	*Health care services* provided by *your* licensed *provider* or clinic and covered by the *Plan*, subject to all of the terms, conditions, limitations and exclusions of the *Plan*.
Custodial Care	Services to assist in *activities of daily living* and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, *bathing*, and *eating*.
Deductible	The amount of *eligible charges* that *you* must *incur* and pay in a *calendar year* before the *Plan* will pay *benefits*.
Dental Specialist	A *dentist* board eligible or certified in the areas of endodontics, *oral surgery*, orthodontics, pedodontics, periodontics, and prosthodontics.
Dentist	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
Designated Transplant Network Provider	Any licensed *hospital*, health care *provider*, group or association of health care *providers* that satisfies the quality, outcome, and accessibility needs of the *Plan* and its *covered persons*, and has contracted to participate as a designated transplant *provider* in the specific *participating provider* network designated by the *Plan* to provide *benefits* for organ or bone marrow transplant or stem cell support and all related services and aftercare for *you*.
Dressing	Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
Eating	Feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

Educational	A service or supply: (1) that is primarily intended to provide training in the *activities of daily living*, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (2) that is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending *physician*.
Effective Date	The date *your* coverage under this *SPD* is effective, which depends on the date that *you* timely complete all applicable enrollment requirements imposed by the *Plan Administrator*.
Eligible Charges	Charges for *health care services*, subject to all of the terms, conditions, limitations and exclusions of the *Plan* and for which the *Plan* or *you* will pay.
*Emergency (*Also *Emergency Medical Condition)*	1. See definition of *emergency medical condition.*
Emergency Department of a Hospital	A *hospital* outpatient department that provides *emergency services.*
*Emergency Medical Condition (*Also *Emergency)*	A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. serious impairment to bodily functions; or 3. serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an *emergency medical condition*:
   a. A medical screening examination that is within the capability of the *emergency department of a hospital* or of an *independent freestanding emergency department*, as applicable, including ancillary services routinely available to the emergency department to evaluate such *emergency medical condition*; and
   b. Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment to *stabilize* the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).
2. Inclusion of additional services:
   a. Unless each of the conditions described in subclause b. are met, items and services:
      i. Which are *covered services*; and
      ii. That are furnished by a *non-participating provider* or non-participating emergency facility (regardless of the department of the *hospital* in which such items or services are furnished) after *you* are *stabilized* and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause 1. are furnished.
   b. Conditions. If *you* are *stabilized* and furnished additional items and services described in subclause a. after such stabilization by a provider or facility described in subclause a., the conditions are the following:
      i. Such provider or facility determines *you* are able to travel using nonmedical transportation or nonemergency medical transportation.
      ii. Such provider furnishing such additional items and services satisfies the notice and consent criteria required by federal law with respect to such items and services.
      iii. *You* are in a condition to receive the information provided in the notice and to provide informed consent, in accordance with applicable federal and state law.
      iv. Any other conditions required by law, such as conditions relating to coordinating care transitions to *participating providers* and facilities.

ERISA

The Employee Retirement Income Security Act of 1974 and the implementing regulations, as amended from time to time.

Essential Health Benefits

The categories of services that qualified health plans are required to cover, as defined and required by the *Affordable Care Act*. The *benefits* covered by this *SPD* may include some *essential health benefits*, but this *SPD* is not and is not intended to be a qualified health plan and does not, and is not required to, cover all *essential health benefits*.

Fee Schedule

The amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* and supplies. This contracted amount may be less than the *provider's* usual charge for the service.

If *health care services* are delivered to *you* via telemedicine by a distant site *participating provider* who is **not** a designated *participating provider* for *virtual care,* the *Plan* will reimburse such *participating provider* on the same basis and using the same *fee schedule* as would apply if the *covered services* had been delivered in person by the distant site *participating provider*.

Formulary

A list, which may change from time to time, of *prescription drugs* which we in our sole discretion, after consideration of recommendations from our Pharmacy and Therapeutics Quality Management Subcommittee, have established for use by the *Plan.*

Full-Time Student Returning from Military Duty	A child of a *covered employee* who meets all of the following criteria: 1. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; 2. The child was under the age of 27 when called to federal active duty; 3. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age; and 4. The child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for the degree. The child continues to be a full-time student during periods of vacation or between term periods established by the school.
Habilitative Care	Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Care Practitioner	One of the following licensed practitioners who perform services payable under this Policy: A *physician*, a *dentist,* physician assistant, advanced practice nurse, mental health professional, a physical therapist, an occupational therapist, a speech-language pathologist, an audiologist, or any other licensed practitioner that is acting within the scope of their license and performing a service that would be payable under the *Plan*.
Health Care Services	Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, surgeries, hospitalizations, or *provider* visits.
Hearing aid	Any externally wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except its batteries and cords.
Home Care	*Health care services* provided directly to *you* in *your* home under a written plan that meets the following criteria: (1) the plan is developed by *your attending health care professional*; (2) the plan is approved by *your attending health care professional* in writing; (3) the plan is reviewed by *your attending health care professional* every two months (or less frequently if *your provider* believes and we agree that less frequent reviews are enough); and (4) *home care* is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.
Homebound	When *you* are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute *homebound* status.
Hospital	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of *physicians* and with 24-hour registered nursing services. The *hospital* is not mainly a place for rest or *custodial care* and is not a nursing home or similar facility.
Implantable Hearing Device	Any implantable instrument or device that is designed to enhance hearing, including *cochlear implants* and *bone anchored hearing aids*.
Incurred	Services and supplies rendered to a *covered person* are considered to be "*incurred*" at the time or date the service or supply was actually purchased or provided.

Independent Freestanding Emergency Department

A health care facility that:

1. is geographically separate and distinct and licensed separately from a *hospital* under applicable State law; and
2. provides any of the *emergency services* listed in section 1. of the definition of *emergency services*.

Independent Review Organization

An entity that conducts independent external reviews of adverse benefit determinations after *you* have exhausted all appeals available to *you* under the internal appeals process.

Infertility

Inability or diminished ability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

1. One year, if *you* are a female under age 35 or a male of any age, or
2. Six months, if *you* are a female age 35 or older,

provided that *your infertility* is not related to voluntary sterilization or failed reversal of voluntary sterilization; or

Inability or diminished ability to produce offspring, including but not limited to a woman's repeated failure to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by *your provider.*

Infertility Treatment/ Fertility Treatment

A *health care service* that is intended to (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy. For purposes of this definition, *infertility treatment* or *fertility treatment* includes, but is not limited to:

1. Fertility tests and *prescription drugs.*
2. Tests and exams done to prepare for or follow through with induced conception.
3. Surgical reversal of a sterilized state that was a result of a previous surgery.
4. Sperm enhancement procedures.
5. Direct attempts to cause or maintain pregnancy by any means including, but not limited to: Hormone therapy or *prescription drugs*; artificial insemination; in vitro insemination; GIFT or ZIFT; embryo transfer; and freezing and/or storage of embryo, eggs, or semen.

Injury

Bodily damage other than *sickness,* including all related conditions and recurrent symptoms.

Investigative

As determined by the *Plan Administrator*, a drug, device or medical treatment or procedure is *investigative* if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and *medical literature*, peer-reviewed journals, or reports of *clinical trial* committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers*, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.

Lethal Fetal Anomaly	An anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.
Maintenance Care	Care that is not *habilitative* or *rehabilitative therapy* and there is lack of documented significant progress in functional status over a reasonable period of time.
Medical Literature	Articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally accepted scientific standards and must not use case reports to satisfy this criterion.
Medically Necessary	Any *health care services*, *preventive health care services*, and other preventive services that *the Plan Administrator,* in its discretion and on a case-by-case basis, determine are appropriate and necessary in terms of type, frequency, level, setting, and duration, for the diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of *providers* in the same or similar general specialty as typically manages the condition procedure or treatment at issue; and 2. Help restore or maintain *your* health; or 3. Prevent deterioration of *your* condition; or 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
Morbid Obesity	Body Mass Index (BMI) that is greater or equal to 40 kg/m2. Patients with a serious medical condition(s), exacerbated by or caused by obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI of 35-39.9 kg/m2 is applied. These serious medical conditions include, but are not limited to, gastroesophageal reflux disease (GERD), hypertension, diabetes, sleep apnea, or arthritis of a weight bearing joint.
Named Fiduciary	The person or organization that has the authority to control and manage the operation and administration of the *Plan*. The fiduciary has discretionary authority to determine eligibility for *benefits* or to construe the terms of the *Plan* and may delegate such discretion to other individuals or entities.
Non-Participating Provider	1. A *physician* or other health care *provider* who, when providing *health care services*, is acting within the scope of practice of that *provider's* license or certification under applicable State law; or 2. A facility, like a clinic or *hospital*; that is not a *participating provider.*
Non-Participating Provider Benefits	Coverage for *health care services* provided by licensed *providers* other than *participating providers*. With *non-participating provider benefits*, *you* are financially responsible for a *deductible, coinsurance,* and any amount in excess of the *usual and customary amount.* Note that the *Plan* may attempt to negotiate a discount with a *non-participating provider.* Such negotiation, if successful, does not change the *provider's* status from a *non-participating provider* to a *participating provider.*
Oral Surgery	Surgical services performed within the oral cavity.
Organ and Tissue Acquisition	The harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to *you*. This includes related medical expenses of a living donor.

Out-of-Network Rate

The term 'out-of-network rate' means, with respect to *emergency services* provided by a *non-participating provider*:

1. Subject to clause 3., the amount determined in accordance with any state law in effect in the state where such *emergency services* were provided;
2. Subject to clause 3., if no such state law which would determine the amount under clause 1. is in effect:
   a. Subject to subclause b., the amount agreed to by Aspirus Health Plan, Inc. and the *non-participating provider*; or
   b. If Aspirus Health Plan, Inc. and the *non-participating provider* enter the independent dispute resolution (IDR) process under the No Surprises Act and do not agree on an amount before a certified IDR entity makes a determination on the amount to be paid to the *non-participating provider*, then the amount determined by the certified IDR entity; or
3. In the case the state has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such All-Payer Model Agreement for such emergency services provided by the non-participating provider.

Out-of-Pocket Limit

The maximum amount of money *you* must pay in *coinsurance* and *deductible* before the *Plan* pays remaining *eligible charges*. If *you* reach *benefit*, day, or visit maximums, *you* are responsible for amounts that exceed the *out-of-pocket limit.*

Participating Provider

1. A licensed clinic, *physician* or other health care *provider* who is acting within the scope of practice of that *provider's* license or certification under applicable State law; or
2. A facility, like a *hospital* or clinic;

that is directly contracted to participate in the specific *participating provider* network designated by the *Plan Administrator* to provide *benefits* to *covered persons* enrolled in this *SPD*. The participation status of *providers* may change from time to time.

Participating providers may also be offered from other Preferred *Provider* Organizations that have contracted with us.

Note that the *Plan* may attempt to negotiate a discount with a *non-participating provider.* Such negotiation, if successful, does not change the *provider's* status from a *non-participating provider* to a *participating provider.*

Participating Provider Benefits

Coverage for *health care services* provided through *participating providers*.

Physical Disability

A condition caused by a physical *injury* or congenital defect to one or more parts of *your* body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to us and as a result *you* are incapable of self-sustaining employment and are dependent on the *covered employee* for a majority of support and maintenance. An illness by itself will not be considered a *physical disability* unless adequate separate proof is furnished to the *Plan Administrator* for the *Plan Administrator* to determine that a *physical disability* also exists as defined in the preceding sentence.

Physician

A licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Optometry, or Doctor of Chiropractic.

Plan

The self-insured employee welfare benefit plan, as defined by *ERISA*, established by the *Plan Sponsor* for the benefit of *covered persons*.

Plan Administrator

The entity, as defined under Section (3)(16) of *ERISA*, that has the exclusive, final and binding discretionary authority to administer the *Plan*, to make factual determinations, to construe and interpret the terms of the *SPD*, *Plan*, and amendments (including ambiguous terms), and to interpret, review, and determine the availability or denial of *benefits*. The *Plan Administrator* may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing *claims* and performing other *Plan*-connected administrative services.

Plan Sponsor — The entity that establishes and maintains the *Plan*, has the authority to amend and/or terminate the *Plan* and is responsible for providing funds for the payment of *benefits*.

Post-Service Claim — A request for payment of *benefits* that is made by *you* or *your* authorized representative after services are rendered and in accordance with the procedures described in this *SPD.*

Prescription Drug — A drug approved by the FDA for use only as prescribed by a *provider* properly authorized to prescribe that drug.

Preventive Health Care Services — The *covered services* that are described in the Preventive Contraceptive Methods and Counseling for Women section and the *Preventive Health Care Services* section of this *SPD*.

Provider — A health care professional, *physician*, or facility licensed, certified, or otherwise qualified under state law that delivers the *health care services* to *you*.

Qualified Health Plan — Health insurance coverage or a group health plan that the Health Insurance Marketplace certifies meets the criteria for certification required under the *Affordable Care Act*; that provides *essential health benefits*; and is offered by a health insurance issuer that meets the requirements of Section 1301(a)(1)(c) of the *Affordable Care Act,* and any related regulations as they may be amended from time-to-time.

Qualifying Payment Amount — The calculation for this amount is to be determined in accordance with the applicable federal regulation. Call Customer Service for further information.

Recognized Amount — With respect to an item or service furnished by a *non-participating provider*:

1. Subject to clause 3., in the case of such item or service furnished in a state that has in effect a law that determines the amount to be paid for such item or service;
2. Subject to clause 3., in the case of such item or service furnished in a state that does not have in effect such a state law, the amount that is the *qualifying payment amount*; or
3. In the case of such item or service furnished in a state with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such system for such item or service.

Reconstructive — *Medically necessary* surgery to restore or correct:

1. a defective body part, when such defect is incidental to or resulting from *injury*, *sickness,* or prior surgery of the involved body part; or
2. a covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a *physician*.

Reconstructive Surgery Following a Mastectomy — Coverage for *covered persons* receiving *covered services* under this *SPD* in connection with a mastectomy and who elect breast reconstruction in connection with such mastectomy will include:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Referral — A formal request or recommendation communicated from your health care *provider* to another *provider* in order to facilitate *your* access to *health care services* for the evaluation, diagnosis, or treatment of a disease or illness.

Rehabilitative Care	Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled within a period of time to meet a *covered person's* maximum potential ability to perform functional daily living activities. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings, unless such services are for chronic medical conditions or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated. Also not considered *rehabilitative care* are *skilled nursing facility* care and home health services.
Rescission	A cancellation or termination of coverage that has retroactive effect. A cancellation or termination of coverage is not a *rescission* if: 1. the cancellation or termination has only a prospective effect, 2. the cancellation or termination is caused by *your* failure to timely pay *your* required premium*s*, or 3. the cancellation or termination is requested by *you* or *your* authorized representative and we, in our sole discretion, agree to allow such request.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency and that provides 24 hour a day care seven days a week, supervision, food, lodging, rehabilitation, or treatment for *sickness* related to mental health and substance use disorders. A *residential treatment facility* does not include halfway houses, community based residential facilities, group homes, or comparable facilities.
Routine Patient Costs	The cost of any *covered services* that would typically be covered if *you* were not enrolled in an approved *clinical trial. Routine patient costs* do not include: 1. the cost of the *investigative* item, device, or service that is the subject of the approved *clinical trial*. 2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management. 3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Serious and Complex Condition	*Serious and complex condition* means, with respect to a *covered person*: 1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or 2. In the case of a chronic illness or condition, a condition that: a. Is life-threatening, degenerative, potentially disabling, or congenital; and b. Requires specialized medical care over a prolonged period of time.
Sickness	Includes physical or mental illness or disease.
Skilled Care	Nursing or *skilled rehabilitation* services requiring the skills of technical or professional medical personnel to provide care or assess the *covered person's* changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for *skilled care*. *Skilled care* does not include care that can be provided by "nonskilled" persons, and therefore does not qualify as *skilled nursing care*, including but not limited to range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing *activities of daily living*, and supervision for potentially unsafe behavior.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, *hospital* swing-bed, and transitional care unit) that provides *skilled care*.

Skilled Rehabilitation	*Skilled rehabilitation* is a type of *skilled care* that helps people recover from an *injury*, surgery or *sickness* provided by health care professionals who can perform or supervise *skilled nursing* or therapy. The goal of *skilled rehabilitation* is to help *you* return to normal life and live as independently as possible.
Specialist	*Providers* other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN, or pediatrics.
Specialty Drugs	Injectable and non-injectable *prescription drugs,* as determined by the *Plan Administrator,* which have one or more of the following key characteristics: 1. frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. there is limited or exclusive product availability and/or distribution; 4. there are specialized product handling, storage and/or administration requirements; or 5. are produced by living organisms or their products.
Stabilize, To	With respect to an *emergency medical condition*, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an *emergency condition* involving a pregnant woman who is having contractions, to deliver (including the placenta).
Stepchild(ren)	A natural or adopted child of the *covered employee's* lawful spouse.
Summary Plan Description (SPD)	The document describing, among other things, the *benefits* offered under the Aspirus St. Luke's Employee Health Benefit Plan HDHP Employee Medical Option of the *Plan* and *your* rights and obligations under such *benefit* option as required by *ERISA*.
Third Party Administrator (TPA)	*Aspirus Health Plan, Inc.* provides administrative services to the Employer in connection with the operation of the *Plan*, including processing of *claims*, as may be delegated to it.
Toileting	Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring	Moving into or out of a bed, chair or wheelchair.
Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
Urgent Care Center	A licensed health care facility that is designed primarily to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
Usual and Customary Amount	The average amount for each *covered service* or supply that by discretion of the *Plan Administrator* is customary in the geographic area in which the *health care service* is provided.
Virtual Care	Care provided by the *Plan's* designated *virtual care* vendor, MDLive. Such care is performed without physical face to face interaction, but through electronic communication allowing evaluation, assessment and the management of services that leads to a treatment plan. *You* can access MDLive at MDLIVE.com/AspirusHealthPlan.
Waiting Period	The period of time that an individual must wait before being eligible for coverage under the *Plan.*
You/Your/Yourself	Refers to *covered person.*

XIX. Specific Information About *Your Plan*

The federal government requires that the following information be furnished for the Aspirus St. Luke's Employee Health Benefit Plan HDHP Employee Medical Option of the *Plan*:

Name of the *Plan*:	This *Plan* shall be known as Aspirus St. Luke's Employee Benefit Plan. This *SPD* replaces, in full, any previously issued Aspirus St. Luke's HDHP Employee Medical Option SPD. This *SPD* is effective January 1, 2026.
Address of the *Plan*:	2200 Westwood Drive Wausau, WI 54401
Type of *Plan*:	Welfare Benefit Plan providing group health *benefits*
Group Number, as assigned by the *TPA*:	ASP20010
Employer Identification Number:	41-0714079
IRS *Plan* Identification Number:	555
***Plan* Year/*Plan* Fiscal Year:**	January 1 through December 31
***Third Party Administrator* or *TPA*:** The company that provides certain administrative services in connection with the *Plan*. *TPA* shall not be deemed an employer with respect to the administration of or provision of *benefits* under *Plan Sponsor's Plan*.	Aspirus Health Plan, Inc. 1900 Westwood Drive PO Box 395 Wausau, WI 54402
***Plan Sponsor* and Sponsor's Address:**	Aspirus, Inc. 2200 Westwood Drive Wausau, WI 54401
***Plan Administrator* and Administrator's Address:** *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, except to the extent it has delegated one or more such responsibilities to others.	Benefits Committee Aspirus, Inc. 2200 Westwood Drive Wausau, WI 54401 (715) 847-2800
***Named Fiduciary*:**	*Plan Sponsor*; Aspirus, Inc.
***Participating Provider*:**	Signature Network
Agent for Service of Legal Process:	Aspirus, Inc. Attention: Human Resources Dept. 2200 Westwood Drive Wausau, WI 54401
Funding:	This is a self-insured plan, not insured by the *TPA* or an insurance carrier; the Employer provides funds from its general assets to pay *claims* under the *Plan*.
***Contributions* and Other Cost Sharing:**	The Employer and the employee share the cost of coverage. This cost sharing involves *contributions*, *deductible* and *coinsurance* costs. *Your* Employer funds and provides *contributions* for the cost of coverage and will inform *you* of *your* share of the *contribution,* which will be used to reimburse the Employer for the cost of coverage it provided. *Your* share of *deductible* and *coinsurance* costs is described elsewhere in this *SPD*.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the privacy practices of Aspirus Health Ventures, Inc. and its subsidiaries, Aspirus Health Plan, Inc. and Aspirus Health Plan of Michigan, Inc. (collectively, "AHP"). AHP is required by law to maintain the privacy of your Protected Health Information ("PHI"), and to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI.

This notice takes effect Sept. 15, 2020, and we must follow its terms until we replace it. AHP reserves the right to amend this notice at any time and may make the revised notice provisions effective for PHI we already have about you, as well as for any such information we may later receive. We will promptly revise and distribute this notice whenever material changes are made to its terms. You may request a copy of this notice at any time.

Uses and Disclosures of Protected Health Information

The following are examples of permitted uses and disclosures of your PHI by AHP. This list of examples is not exhaustive.

Treatment. We may disclose your PHI to a health care provider for you to receive medical care from the provider.

Payment. We may use and disclose your PHI to pay for your covered benefits. For example, we may review PHI to pay for your claims from physicians, hospitals, and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, and to obtain premiums.

Health Care Operations. We may use and disclose your PHI in connection with our health care operations, including such activities as:

- Quality assessment and improvement activities;
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider
- performance, conducting training programs, accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits. We will not use or disclose genetic information for underwriting purposes;
- Conducting or arranging for medical review, legal
- services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

In addition, AHP participates in one or more Organized Health Care Arrangements. Members of an Organized Health Care Arrangement may share information with each other for treatment, payment, or health care operation purposes described in this notice.

Business Associates. We may disclose your PHI to business associates of AHP to provide necessary services to AHP, if such business associates have agreed in writing to protect the confidentiality of your PHI.

Plan Sponsors. If you are covered under a group health plan, we may disclose your eligibility, enrollment, and disenrollment information to the plan sponsor. We may disclose your PHI to the plan sponsor to permit the plan sponsor to perform certain administrative functions on behalf of the plan, but only if the plan sponsor agrees in writing to use the PHI appropriately and to protect it as required by law.

Persons Involved With Your Care. We may disclose your relevant PHI to family members, friends, or others that you identify as being involved with your health care or with payment for your health care. Before doing so, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your

incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Disasters and Medical Emergencies. We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Health-Related Benefits and Services. We may use and disclose your PHI to contact you with information about treatment alternatives, appointment reminders, or other health-related benefits and services that may be of interest to you.

Required Disclosures. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if necessary for an investigation being conducted by the Secretary; and upon request, to you or to individuals authorized by you, such as your personal representative.

Other Uses or Disclosures Permitted or Required by Law. We may use or disclose your PHI as permitted or required by law for the following purposes:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state workers' compensation laws.

Written Authorization. Unless you give us your written authorization, we will not use or disclose your PHI for purposes other than those described in this notice. We will not sell your PHI, or use or disclose your PHI for marketing purposes, or use or disclose your psychotherapy notes, except as permitted by law, unless we have received your written authorization. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

Individual Rights

Inspect and Copy. With certain exceptions, you have the right to inspect or copy the PHI that we maintain on you. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge you a reasonable, cost-based fee for staff time to locate and copy your PHI, and postage if you want the copies mailed to you. If we deny your request to access and inspect your information, you may request a review of the denial.

Amendment. You have the right to request that we amend the PHI that we maintain on you. Your request must be in writing and must provide a reason to support the requested amendment. We may deny your request to amend PHI if we did not create it and the originator remains available; if it is accurate and complete; if it is not part of the information that we maintain; or if it is not part of the information that you would be permitted to inspect and copy. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended.

Confidential Communications. You have the right to request to receive communications of your PHI from us by alternative means or at alternative locations. We must accommodate your request if it is reasonable; if it specifies the alternative means or location; if it clearly states that the disclosure of all or part of the information could endanger you; and if it continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the contract holder of the health plan in which you participate. An explanation of benefits issued to the contract holder for health care that you received for which you did not request confidential communications may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Request Restrictions. You have the right to request restrictions on how we use or disclose PHI about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency). Your restriction request must be made to us in writing. A person authorized to make such an agreement on our behalf must sign any agreement to restrictions. We will not agree to restrictions on uses or disclosures that are legally required, or which are necessary for us to administer our business.

Disclosure Accounting. You have a right to receive an accounting of the disclosures we have made of your PHI. This accounting will not include disclosures made for treatment, payment, health care operations, to law enforcement or corrections personnel, pursuant to your authorization, directly to you, or for certain other activities. Your request for an accounting must be made in writing to us and must state the time period, which may not be longer than six years, from which you would like to receive the accounting. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Breach Notification. You have the right to be notified by us if there is a breach of your unsecured PHI.

Copy of Notice. You are entitled to receive this notice in written form, even if you have received it on our website or by electronic mail (email). Please contact us using the information listed at the end of this notice to obtain a written copy of the notice.

Protection of PHI. AHP is committed to ensuring that your PHI is protected from unauthorized use or disclosure. We have implemented strong security measures and processes to keep oral, written, and electronic PHI secure across our organization. For example, an employee or contractor who accesses your PHI must comply with all of our information security requirements including, but not limited to, signing confidentiality agreements, completing annual information security training, and using encryption when transmitting data to an external party.

Questions and Complaints

If you believe that AHP may have violated your privacy rights, or if you disagree with a decision we made regarding one of the individual rights provided to you under this notice, you may submit a complaint to us using the contact information provided at the end of this notice. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you in any way if you choose to file a complaint regarding our privacy practices with us or with the U.S. Department of Health and Human Services.

Nonpublic Personal Information Privacy Practices

Aspirus Health Ventures, Inc. and its subsidiaries, Aspirus Health Plan, Inc. and Aspirus Health Plan of Michigan, Inc. (collectively, “AHP”), are committed to protecting the confidential information of our customers. We at AHP value our relationship with you and take the protection of your personal information very seriously. This notice describes our privacy policy and explains the types of information we collect, how we collect it, and to whom we may disclose it.

Information We May Collect. AHP may collect and use nonpublic personal information about you from the following sources:

- Information we receive from you on applications and other forms that are provided to us, such as your name, address, Social Security number, date of birth, marital status, dependent information, employment information, and medical history;
- Information about your transactions with us, our affiliates, and others, such as health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information; and
- Information we receive from consumer reporting agencies, employers, and insurance companies, such as credit history, creditworthiness, and information verifying employment history or insurance coverage.

Information We May Disclose. AHP does not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We share nonpublic personal information only to the extent necessary for us to take care of our customers’ claims and other transactions involving our products and services.

When necessary, we share a customer's nonpublic personal information with our affiliates and disclose it to health care providers, other insurers, third- party administrators, payors, vendors, consultants, government authorities, and their respective agents. These parties are required to keep nonpublic personal information confidential as required by law.

AHP does not share nonpublic personal information with other companies for their own marketing purposes. AHP may disclose such information to companies, which must keep it confidential as required by law, that perform marketing services on our behalf or to other companies with which we have joint marketing agreements.

Confidentiality and Security. At AHP, we restrict access to nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards to protect nonpublic personal information against unauthorized access and use. These safeguards comply with federal regulations on the protection of nonpublic personal information.

AHP will amend this notice as necessary and appropriate to protect nonpublic personal information about our customers.

Further Information. For additional information regarding this notice or our privacy practices in general, please call the AHP Privacy Officer at 715-843-1391, Monday through Friday, 8 a.m. to 5 p.m., or write to us at:

Privacy Officer
Aspirus Health Plan
2200 Westwood Drive
Wausau, WI 54401