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**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR  
CITY OF CASPER EMPLOYEE  
HEALTH BENEFIT PLAN**

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**ESPAÑOL:** Para obtener asistencia en Español, llame al 877-321-4412.

## INTRODUCTION

This document is a description of City of Casper Employee Health Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, copayments, maximums, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Health Care Plan Privacy Notice.** Explains how medical information may be used, disclosed and accessed.

**Open Enrollment.** Explains some options for enrollment and benefit selection.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

### **ELIGIBILITY**

**Eligible Classes of Employees.** All Active and Retired Employees of the Employer.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she works an average of 40 hours or more per week and is on the regular payroll of the Employer for that work.
- (2) is a Retired Employee of the Employer. Retirees of any age whether over or under age 65, who are eligible for Medicare, are required to enroll in both Medicare A and Medicare B in order to stay covered on the City of Casper Benefit Plan. Benefits will be provided on a carve-out basis where Medicare A and B shall be the primary coverage and this Plan shall be secondary.

NOTE: Any new employee, who starts January 1, 2012 or thereafter, will not be eligible to stay on the City's health plan when/if they retire from the City of Casper.

Retired Employees (and Dependents) who allow their Retiree Coverage to terminate will NOT be eligible to reapply later for coverage. All Dependents of a covered retired Employee who were covered at the time that the Employee retired are eligible.

Except as otherwise required by state or federal law, newly acquire Dependents who were not covered at the time the Employee retired are not eligible to be added to coverage under this Plan.

- (3) is a member of the City Council.
- (4) is in a class eligible for coverage.
- (5) completes the employment Waiting Period of 30 consecutive days as an Active Employee. This waiting period applies only to those hired after July 1, 2009.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

**Eligible Classes of Dependents.** A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall not include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

- (2) A covered Employee's Child(ren).

An Employee's "Child" includes his or her natural child, stepchild, (as long as a natural parent remains married to the Employee and resides in the Employee's household), foster child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- (3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Any Child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

(4) A covered Employee's Totally Disabled Child(ren).

A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

**These persons are excluded as Dependents:** other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; grandchildren of the Employee or Retirees; domestic partners or the common-law spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

**Surviving Spouse Eligibility.** Surviving spouses, and dependents, who are active participants in the Plan at the time of the employee or retiree's death, will be allowed to continue their participation as if they were currently employed full-time or had retired themselves, providing they continue to pay the applicable premium. Surviving spouses and dependents of current employees will not be eligible for this benefit unless they have been active participants in the Plan for at least 12 months prior to the employee's death. Also, surviving spouses and dependents of current employee will be required to pay the entire applicable premium (both the employer and employee portions).

If the surviving spouse remains a participant and then remarries, he/she would be allowed to continue single coverage for themselves or family coverage for themselves and their dependents, but not allowed to add the new spouse as a dependent.

If the surviving spouse allows the coverage to terminate, he/she will not be eligible to reapply for coverage at a later date.

## FUNDING

**Cost of the Plan.** City of Casper shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for coverage by either filling out and signing an enrollment application, which also acts as a payroll deduction authorization, or enrolling via the on-line enrollment portal. A newborn child will be automatically enrolled for 31 days from birth.

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. An enrollment/change form must be signed by the Employee within 31 days of birth in order for the newborn to have coverage beyond the first 31 days of life. Otherwise, the dependent can be added at the next Open Enrollment.

Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

## TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If 2 Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during Open Enrollment (September 9<sup>th</sup> through September 30<sup>th</sup>).

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

## **SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself/herself or his/her dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Plan allows Special Enrollments Rights in the event a Participant or his or her eligible Dependent (1) loses coverage under Medicaid or a state child health program, or (2) becomes eligible for state assistance with respect to paying his or her contributions to the Plan, as follows:

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, City of Casper, 200 North David, Casper, Wyoming, 82601, (307) 235-8344.

## **SPECIAL ENROLLMENT PERIODS**

If Enrolled under Special Enrollment, the first date of coverage is the date of the Qualifying Event. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:
  - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.



**(3) Dependent beneficiaries. If:**

- (a)** The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b)** A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31 day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a)** in the case of marriage, on the date of marriage or the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b)** in the case of a Dependent's birth, as of the date of birth; coverage will continue as long as a completed request for enrollment is received within 31 days of the birth; or
- (c)** in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption as long as a completed request for enrollment is received within 31 days of the date of adoption or placement for adoption.

**(4) Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a)** The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a state Child Health Insurance Plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

- (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

## **EFFECTIVE DATE**

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

### **Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met as stated above; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## **TERMINATION OF COVERAGE**

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.**

**The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or**

**misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.**

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is eliminated.
- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

**Continuation During Periods of Employer-Certified Disability or Leave of Absence or Layoff.** A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

**For disability leave only:** available under the guidelines of the Family Medical Leave Act (FMLA) only.

**For non-military leave of absence only:** FMLA (if eligible) and up to 90 additional days annually for illness or injury for the immediate family necessitating the Employee's attendance. Requires department manager approval.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

**Employees on Military Leave of Absence.** A Military leave of absence will be in addition to any other leave or vacation time to which the Employee is entitled. Length of service will continue to accrue during a military leave of absence. Vacation and disability leave will continue to accrue, subject to the City's Rules and Regulations, or any amendments there to, while the Employee is on military leave.

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

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
  - (a) The 24 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) Military personnel returning from Active Duty will be reinstated under the City of Casper's health insurance plan with no initial 'waiting period' or exclusion for pre-existing conditions. Coverage will begin upon notification to resume City employment, assuming that he or she is at that time ready to return to work. This ensures that the City of Casper's returning service people are covered in the event that the City cannot provide them with a position immediately.

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

The City of Casper will continue to pay its portion so the Employee's health, dental and life insurance premiums while the Employee is on a **Paid Military Leave**.

When an Employee is placed on an **Unpaid Military Leave**, the Employee has the option to continue their participation in the City of Casper health, dental and life insurance plans. Employees on **Unpaid Military Leave** will be required to continue paying the Employee portion of the monthly premium for health and life insurance coverage.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator City of Casper, 200 North David, Casper, Wyoming, 82601, (307) 235-8344. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) On the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) On the day that a Dependent child reaches their 26<sup>th</sup> birthday.
- (6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

- (7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

## HEALTH CARE PLAN PRIVACY NOTICE

**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.**

The City of Casper Employee Health Benefit Plan (the Plan) is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any identifiable information that the Plan obtains from you or others that relate to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and the Plan's legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures the Plan will make of your protected health information. If there is a breach of your unsecured protected health information, you have the right to be notified of the breach.

**Permitted Uses and Disclosures.** The Plan can use or disclose your protected health information for purposes of treatment, payment and health care operations. Except as noted below, uses and disclosures not described in this notice will be made only with your authorization.

Treatment means the provision, coordination or management of your health care, including any referrals for health care from one health care provider to another. For example, a provider under the Plan may need to know health care information in Plan files that might assist in treatment.

Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the Plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

As another example, prior to providing health care services, the Plan may need information from a provider about your Medical Condition to determine whether the proposed course of treatment will be covered. When the Plan receives a bill from the provider, the Plan can obtain information regarding your care if necessary to provide payment.

Health care operations means the support function related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, Physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, the Plan may use your medical information to evaluate the performance of providers used in the Plan. The Plan may also combine medical information about many patients to decide how to better provide needed benefits under the Plan.

**Other Uses and Disclosures of Protected Health Information.** The Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Plan may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care.

The Plan may not use your genetic information for any underwriting purpose.

The Plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The Plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, the Plan will give you an opportunity to object to these disclosures, and the Plan will not make these disclosures if you object. If you are not available, the Plan will determine whether a disclosure to your family or friends is in your best interest, and the Plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, the Plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Most uses and disclosures of psychotherapy notes, and uses and disclosures of protected health information for marketing purposes or that are considered to be a “sale” of protected health information can only be made with your written authorization. Except for the situations listed below, the Plan will not use or disclose your protected health information for any other purpose unless you provide written authorization.

You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that the Plan already has taken action in reliance on your authorization.

**Exceptional Situations.** The Plan may use or disclose your protected health information in the following situations without your authorization:

- **Coroners, Medical Examiners and Funeral Directors.** The Plan may release medical information to the coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.
- **Health Oversight Activities.** The Plan may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. The Plan may disclose protected health information to persons under the Food and Drug Administration’s jurisdiction to track products or to conduct post-marketing surveillance.
- **Inmates.** If you become an inmate of a correctional institution or fall under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

- **Law Enforcement.** The Plan may release medical information in these situations: if asked to do so by law enforcement official in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances and are unable to obtain the person's agreement; about a death believed may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Military and Veterans.** If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities.** The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Protective Services for the President and Others.** The Plan may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Public Health Risks.** The Plan may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if believed a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.
- **Serious Threats.** As permitted by applicable law and standards of ethical conduct, the Plan may use and disclose protected health information if, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- **Workers' Compensation.** The Plan may release medical information about you for programs that provide benefits for work-related injuries or illness.

## Your Rights

- You have the right to request restrictions on the Plan's uses and disclosures of protected health information for treatment, payment and health care operations. However, the Plan is not required to agree to your request. If you pay a provider of health care out of pocket in full for the cost of your treatment, you can request that the provider not to share information about your treatment with the Plan. The health care provider must comply with your request.
- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
- Subject to payment of a reasonable fee for labor and copying, and the exceptions noted below, you have the right to inspect and copy the protected health information contained in the Plan's records. If you cannot afford to pay for copies, you will not be denied access. You have the right to ask for a copy of your electronic medical record in a reasonable electronic format. In some instances the Plan may not have to provide you with copies of psychotherapy notes, information compiled in relation to a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If your request for access is denied you will be informed in writing, and you can ask the Plan to review the decision. Not all denials are subject to review. You have the right to request a correction to your protected health information, but the Plan may deny your request for correction.

Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

- You have the right to receive an accounting of disclosures of protected health information made by the Plan to individuals or entities other than to you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; or that occurred prior to April 14, 2003.
- You have the right to request and receive a paper copy of this notice from us.

**Effective Date and Changes.** This notice is effective as of September 23, 2013. The Plan reserves the right to change the terms of this notice from time-to-time and to make the revised notice effective for all protected health information the Plan maintains. The Plan must follow the terms of the notice currently in effect for any planned use or disclosure of protected health information. You can always request a copy of our most current privacy notice from our office or you can access it on our web site. We will tell you about changes to this notice by posting the notice on our website and mailing you a copy of the revised notice with the next annual mailing after the notice takes effect.

**Filing a Complaint.** If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer at (307) 235-8344. The Plan will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

**Contact Person and Exercising Your Rights.** To exercise any of the rights described in this notice you must make a written request. Mail your request to: City of Casper, 200 North David, Casper, Wyoming 82601; or If you have any questions or would like further information about this notice, please contact City of Casper at (307) 235-8344.

## OPEN ENROLLMENT

Every September 9 through September 30, the annual open enrollment period, covered Employees and their covered Dependents will be able to **change** some of their benefit decisions based on which benefits and coverages are right for them.

Every September 9 through September 30, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to **enroll** in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

## SCHEDULE OF BENEFITS

**Verification of Eligibility** (877) 321-4412 or (719) 622-3300

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

### MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan is a traditional medical benefits plan. Covered Persons may choose any Physician or Hospital without the reimbursement levels from the Plan being affected.

**Note: The following services must be precertified or reimbursement from the Plan may be reduced.**

- **Inpatient Hospitalizations**
- **Inpatient Hospice Care**
- **Inpatient Rehabilitation**
- **Outpatient Infusion, Chemotherapy and Radiation therapy (no pre-certification penalty applies to Chemo or Radiation therapy)**
- **Clinical Trials**
- **Outpatient Surgical procedures not performed in a physician's office, except for routine colonoscopies**

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

**Please see the Cost Management section in this booklet for details.**

The Plan contains the following Network Provider Organizations:

<b>LOCATION</b>	<b>NAME</b>	<b>PHONE #</b>	<b>WEB SITE</b>
Wyoming	WISE Provider Network	(866) 485-5205	<a href="http://www.wiseprovider.net">www.wiseprovider.net</a>
Colorado	Rocky Mountain Health Plan/ASO Network	(800) 426-7453	<a href="http://www.rmhp.org">www.rmhp.org</a>
All other locations	PHCS Healthy Directions	(800) 678-7427	<a href="http://www.multiplan.com">www.multiplan.com</a>

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

### **Deductibles/Copayments payable by Plan Participants**

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

Deductibles accrue toward the out-of-pocket 100% payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

**Incentive for Plan Savings.** Covered Employees may be eligible for a financial reward for saving the Plan money.

**Bill Audit.** If the Covered Employee identifies an incorrect charge on a hospital, physician, or ancillary (radiology, pathology, laboratory, etc.) billing and obtains a corrected billing, the Employee will receive a reward of 50% of the savings to the Plan. The minimum reward is \$25 on a \$50 savings, and the maximum reward is \$1,250 for savings to the Plan of \$2,500 or more. To claim the reward, the Covered Employee obtains a corrected billing from the provider and submits it with the original billing and a note detailing the discrepancy.

**Alternative Vendor.** If the Covered Employee identifies a more cost effective source of services or supplies covered under the Plan, the Employee will receive a reward of 50% of the savings to the Plan. The minimum reward is \$25 on a \$50 savings, and the maximum reward is \$1,250 for savings to the Plan of \$2,500 or more. To determine if the proposed alternative source of services or supplies will be covered by the Plan, the Employee contacts CNIC Care Management with the details of the proposed alternative arrangement prior to obtaining the services or supplies. If the arrangement is approved by Care Management, the Employee submits the Care Management approval after the claim is paid to claim the reward.

## MEDICAL BENEFITS SCHEDULES

<b>BUY UP PLAN</b>	
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>	
Per Covered Person	\$750
Per Family Unit	\$1,500
The Calendar Year deductible is waived for the following Covered Charges: Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable except for all preventive care services and routine colonoscopies (1 per Calendar Year)	
<b>COPAYMENTS (Network Providers Only)</b>	
Physician's office visit	\$20
Specialist office visit	\$20
Outpatient lab	\$20
Mental Health and Substance Abuse outpatient office visits	\$20
Urgent Care	\$20
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>	
Per Covered Person	\$2,000
Per Family Unit	\$4,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Copayments Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable	
<b>COVERED CHARGES</b>	
<b>Ambulance Service</b>	
Ground transportation	80% after deductible
Air ambulance	80% after deductible
<b>Cardiac Rehabilitation</b>	80% after deductible 3 sessions per week; 36 session maximum
<b>Diagnostic X-ray and Lab Expenses (including interpretation fees)</b>	
Physician's Office/ Outpatient Hospital/ Ambulatory Surgery Center	
Lab Charges	
Outpatient – Network Provider	100% after \$20 copayment
Outpatient – Non- Network Provider	80% after deductible
X-Ray Charges	80% after deductible
Imaging Charges (MRI, etc.)	80% after deductible
<b>Durable Medical Equipment</b>	80% after deductible
<b>Home Health Care</b>	100% after deductible 60 visit Calendar Year maximum
<b>Hospice Care</b>	
In-Home or Inpatient Care	100% after deductible
Acute Inpatient	100% after deductible
Bereavement Counseling	80% after deductible (Within 3 months of death)

<b>BUY UP PLAN</b>	
<b>Hospital Services</b>	
Room and Board	80% after deductible Semiprivate room rate
Intensive Care Unit	80% after deductible
Outpatient Hospital / Ambulatory Surgery Center	80% after deductible
<b>Emergency Room Visits</b>	
Emergency Room	80% after deductible
<b>Infertility</b>	
Coverage includes: care supplies and services for the <b>diagnosis of infertility only.</b>	
<b>Jaw Joint/TMJ Treatment</b> (Surgery not covered)	80% after deductible \$2,000 Lifetime maximum
<b>Mental Disorders and Substance Abuse Treatment</b>	
<b>Mental Disorder Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$20 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Substance Abuse Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$20 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Newborn Nursery Care</b>	80% after deductible
<b>Organ Transplants</b>	
All eligible charges	80% after deductible
Donor Expenses	\$10,000 Lifetime maximum
Travel, Meals and Lodging	\$10,000 Lifetime maximum
<b>Physician Services</b>	
Inpatient hospital visits	80% after deductible
Office visits and eligible lab expenses incurred during visit (Network Providers)	100% after \$20 copayment
Office visits and all eligible expenses incurred during visit, including surgery (Non-Network Providers)	80% after deductible
Inpatient and outpatient surgery	80% after deductible
Physician emergency room visits	80% after deductible
Allergy testing	80% after deductible
Allergy serum and injections	80% after deductible
<b>Preadmission Testing</b>	100% (deductible waived)
<b>Pregnancy</b>	
Routine Prenatal office visits	100% (deductible waived)
Includes certain lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and certain immunizations as required under health care reform). Dependent children are not covered for pregnancy or complications of pregnancy.	
Inpatient and Delivery	80% after deductible

<b>BUY UP PLAN</b>	
<b>Private Duty Nursing</b> (inpatient only)	80% after deductible
<b>Prosthetics</b>	80% after deductible
For initial prosthetic only; replacement only if significant change in covered person's condition.	
<b>Rehabilitation Therapies – Inpatient and Outpatient</b> (Includes Occupational, Speech and Physical Therapy)	
Eligible expenses	80% after deductible Limited to 12 visits with no written prescription; unlimited visits with a written prescription.
<b>Routine Well Adult and Child Care</b>	100% (deductible waived)
<p>Includes: Standard Preventive Care, office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, hearing tests, vision tests, immunizations/flu shots, obesity/weight loss program, tobacco cessation program, colonoscopies, bone density scans and stress tests.</p> <p>Coverage also includes all recommended preventive services that have a rating of "A" or "B" from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. From January 1, 2014 through December 31, 2014, these covered preventive services are those services posted on the U.S. Department of Health and Human Services website between January 1, 2013 and December 31, 2013 unless otherwise required by law. Recommendations made subsequent to December 31, 2013 will be handled in a similar manner for January 1, 2015 and thereafter. This website is located at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a></p> <p>Charges for routine Colonoscopy screenings are covered at 100% under Routine Well Adult Care and are limited to 1 per Calendar year. This includes removal of a polyp(s) at the time of the colonoscopy and any related charges over reasonable and customary. Any additional colonoscopies performed within the same Calendar Year will be subject to deductible, coinsurance and any related charges over reasonable and customary.</p> <p>Note: Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). See the Prescription Drug Benefits Section.</p>	
<b>Second and Third Opinion</b>	80% after deductible
<b>Skilled Nursing Facility</b> (Convalescent Care within 14 days of a 3 day hospital stay)	80% after deductible Semiprivate room rate 90 days Calendar Year maximum
<b>Spinal Manipulations / Chiropractic</b> – Network Provider – Non- Network Provider	100% after \$20 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Acupuncture</b> – Network Provider – Non- Network Provider	100% after \$20 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Surgical Sterilization –</b> Male and Female	80% (deductible waived)
<b>Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)</b>	
Emergency or illness care	100% after \$20 copayment
<b>All other Eligible Expenses</b>	80% after deductible

<b>MID OPTION PLAN</b>	
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>	
Per Covered Person	\$1,500
Per Family Unit	\$3,000
The Calendar Year deductible is waived for the following Covered Charges: Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable except for all preventive care services and routine colonoscopies (1 per Calendar Year)	
<b>COPAYMENTS (Network Providers Only)</b>	
Physician's office visit	\$35
Specialist office visit	\$35
Outpatient lab	\$35
Mental Health and Substance Abuse outpatient office visits	\$35
Urgent Care	\$35
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>	
Per Covered Person	\$3,000
Per Family Unit	\$6,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Copayments Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable	
<b>COVERED CHARGES</b>	
<b>Ambulance Service</b>	
Ground transportation	80% after deductible
Air ambulance	80% after deductible
<b>Cardiac Rehabilitation</b>	80% after deductible 3 sessions per week; 36 session maximum
<b>Diagnostic X-ray and Lab Expenses (including interpretation fees)</b>	
Physician's Office/ Outpatient Hospital/ Ambulatory Surgery Center	
Lab Charges	
Outpatient – Network Provider	100% after \$35 copayment
Outpatient – Non- Network Provider	80% after deductible
X-Ray Charges	80% after deductible
Imaging Charges (MRI, etc.)	80% after deductible
<b>Durable Medical Equipment</b>	80% after deductible
<b>Home Health Care</b>	100% after deductible 60 visit Calendar Year maximum
<b>Hospice Care</b>	
In-Home or Inpatient Care	100% after deductible
Acute Inpatient	100% after deductible
Bereavement Counseling	80% after deductible (Within 3 months of death)

<b>MID OPTION PLAN</b>	
<b>Hospital Services</b>	
Room and Board	80% after deductible Semiprivate room rate
Intensive Care Unit	80% after deductible
Outpatient Hospital / Ambulatory Surgery Center	80% after deductible
<b>Emergency Room Visits</b>	
Emergency Room	80% after deductible
<b>Infertility</b>	
80% after deductible	
Coverage includes: care supplies and services for the <b>diagnosis of infertility only.</b>	
<b>Jaw Joint/TMJ Treatment</b> (Surgery not covered)	80% after deductible \$2,000 Lifetime maximum
<b>Mental Disorders and Substance Abuse Treatment</b>	
<b>Mental Disorder Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$35 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Substance Abuse Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$35 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Newborn Nursery Care</b>	80% after deductible
<b>Organ Transplants</b>	
All eligible charges	80% after deductible
Donor Expenses	\$10,000 Lifetime maximum
Travel, Meals and Lodging	\$10,000 Lifetime maximum
<b>Physician Services</b>	
Inpatient hospital visits	80% after deductible
Office visits and eligible lab expenses incurred during visit (Network Providers)	100% after \$35 copayment
Office visits and all eligible expenses incurred during visit, including surgery (Non-Network Providers)	80% after deductible
Inpatient and outpatient surgery	80% after deductible
Physician emergency room visits	80% after deductible
Allergy testing	80% after deductible
Allergy serum and injections	80% after deductible
<b>Preadmission Testing</b>	100% (deductible waived)
<b>Pregnancy</b>	
Routine Prenatal office visits	100% (deductible waived)
Includes certain lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and certain immunizations as required under health care reform). Dependent children are not covered for pregnancy or complications of pregnancy.	
Inpatient and Delivery	80% after deductible

<b>MID OPTION PLAN</b>	
<b>Private Duty Nursing</b> (inpatient only)	80% after deductible
<b>Prosthetics</b>	80% after deductible
For initial prosthetic only; replacement only if significant change in covered person's condition.	
<b>Rehabilitation Therapies – Inpatient and Outpatient</b> (Includes Occupational, Speech and Physical Therapy)	
Eligible expenses	80% after deductible Limited to 12 visits with no written prescription; unlimited visits with a written prescription.
<b>Routine Well Adult and Child Care</b>	100% (deductible waived)
<p>Includes: Standard Preventive Care, office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, hearing tests, vision tests, immunizations/flu shots, obesity/weight loss program, tobacco cessation program, colonoscopies, bone density scans and stress tests.</p> <p>Coverage also includes all recommended preventive services that have a rating of “A” or “B” from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. From January 1, 2014 through December 31, 2014, these covered preventive services are those services posted on the U.S. Department of Health and Human Services website between January 1, 2013 and December 31, 2013 unless otherwise required by law. Recommendations made subsequent to December 31, 2013 will be handled in a similar manner for January 1, 2015 and thereafter. This website is located at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a></p> <p>Charges for routine Colonoscopy screenings are covered at 100% under Routine Well Adult Care and are limited to 1 per Calendar year. This includes removal of a polyp(s) at the time of the colonoscopy and any related charges over reasonable and customary. Any additional colonoscopies performed within the same Calendar Year will be subject to deductible, coinsurance and any related charges over reasonable and customary.</p> <p>Note: Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). See the Prescription Drug Benefits Section.</p>	
<b>Second and Third Opinion</b>	80% after deductible
<b>Skilled Nursing Facility</b> (Convalescent Care within 14 days of a 3 day hospital stay)	80% after deductible Semiprivate room rate 90 days Calendar Year maximum
<b>Spinal Manipulations / Chiropractic</b> – Network Provider – Non- Network Provider	100% after \$35 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Acupuncture</b> – Network Provider – Non- Network Provider	100% after \$35 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Surgical Sterilization –</b> Male and Female	80% (deductible waived)
<b>Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)</b>	
Emergency or illness care	100% after \$35 copayment
<b>All other Eligible Expenses</b>	80% after deductible

<b>BUY DOWN PLAN</b>	
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>	
Per Covered Person	\$2,500
Per Family Unit	\$5,000
The Calendar Year deductible is waived for the following Covered Charges: Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable except for all preventive care services and routine colonoscopies (1 per Calendar Year)	
<b>COPAYMENTS (Network Providers Only)</b>	
Physician's office visit	\$50
Specialist office visit	\$50
Outpatient lab	\$50
Mental Health and Substance Abuse outpatient office visits	\$50
Urgent Care	\$50
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>	
Per Covered Person	\$5,000
Per Family Unit	\$10,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Copayments Cost containment penalties Non-Covered charges and charges in excess of Plan maximums Charges over Usual and Reasonable	
<b>COVERED CHARGES</b>	
<b>Ambulance Service</b>	
Ground transportation	80% after deductible
Air ambulance	80% after deductible
<b>Cardiac Rehabilitation</b>	80% after deductible 3 sessions per week; 36 session maximum
<b>Diagnostic X-ray and Lab Expenses (including interpretation fees)</b>	
Physician's Office/ Outpatient Hospital/ Ambulatory Surgery Center	
Lab Charges	
Outpatient – Network Provider	100% after \$50 copayment
Outpatient – Non- Network Provider	80% after deductible
X-Ray Charges	80% after deductible
Imaging Charges (MRI, etc.)	80% after deductible
<b>Durable Medical Equipment</b>	80% after deductible
<b>Home Health Care</b>	100% after deductible 60 visit Calendar Year maximum
<b>Hospice Care</b>	
In-Home or Inpatient Care	100% after deductible
Acute Inpatient	100% after deductible
Bereavement Counseling	80% after deductible (Within 3 months of death)

<b>BUY DOWN PLAN</b>	
<b>Hospital Services</b>	
Room and Board	80% after deductible Semiprivate room rate
Intensive Care Unit	80% after deductible
Outpatient Hospital / Ambulatory Surgery Center	80% after deductible
<b>Emergency Room Visits</b>	
Emergency Room	80% after deductible
<b>Infertility</b>	80% after deductible
Coverage includes: care supplies and services for the <b>diagnosis of infertility only.</b>	
<b>Jaw Joint/TMJ Treatment</b> (Surgery not covered)	80% after deductible \$2,000 Lifetime maximum
<b>Mental Disorders and Substance Abuse Treatment</b>	
<b>Mental Disorder Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$50 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Substance Abuse Treatment</b>	
Inpatient Hospitalization	80% after deductible
Outpatient Facility	80% after deductible
Outpatient Physician's Office Visits (Network Providers)	100% after \$50 copayment
Outpatient Physician's Office Visits (Non-Network Providers)	80% after deductible
<b>Newborn Nursery Care</b>	80% after deductible
<b>Organ Transplants</b>	
All eligible charges	80% after deductible
Donor Expenses	\$10,000 Lifetime maximum
Travel, Meals and Lodging	\$10,000 Lifetime maximum
<b>Physician Services</b>	
Inpatient hospital visits	80% after deductible
Office visits and eligible lab expenses incurred during visit (Network Providers)	100% after \$50 copayment
Office visits and all eligible expenses incurred during visit, including surgery (Non-Network Providers)	80% after deductible
Inpatient and outpatient surgery	80% after deductible
Physician emergency room visits	80% after deductible
Allergy testing	80% after deductible
Allergy serum and injections	80% after deductible
<b>Preadmission Testing</b>	100% (deductible waived)
<b>Pregnancy</b>	
Routine Prenatal office visits	100% (deductible waived)
Includes certain lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and certain immunizations as required under health care reform). Dependent children are not covered for pregnancy or complications of pregnancy.	
Inpatient and Delivery	80% after deductible

<b>BUY DOWN PLAN</b>	
<b>Private Duty Nursing</b> (inpatient only)	80% after deductible
<b>Prosthetics</b>	80% after deductible
For initial prosthetic only; replacement only if significant change in covered person's condition.	
<b>Rehabilitation Therapies – Inpatient and Outpatient</b> (Includes Occupational, Speech and Physical Therapy)	
Eligible expenses	80% after deductible Limited to 12 visits with no written prescription; unlimited visits with a written prescription.
<b>Routine Well Adult and Child Care</b>	100% (deductible waived)
<p>Includes: Standard Preventive Care, office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, hearing tests, vision tests, immunizations/flu shots, obesity/weight loss program, tobacco cessation program, colonoscopies, bone density scans and stress tests.</p> <p>Coverage also includes all recommended preventive services that have a rating of “A” or “B” from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. From January 1, 2014 through December 31, 2014, these covered preventive services are those services posted on the U.S. Department of Health and Human Services website between January 1, 2013 and December 31, 2013 unless otherwise required by law. Recommendations made subsequent to December 31, 2013 will be handled in a similar manner for January 1, 2015 and thereafter. This website is located at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a></p> <p>Charges for routine Colonoscopy screenings are covered at 100% under Routine Well Adult Care and are limited to 1 per Calendar year. This includes removal of a polyp(s) at the time of the colonoscopy and any related charges over reasonable and customary. Any additional colonoscopies performed within the same Calendar Year will be subject to deductible, coinsurance and any related charges over reasonable and customary.</p> <p>Note: Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). See the Prescription Drug Benefits Section.</p>	
<b>Second and Third Opinion</b>	80% after deductible
<b>Skilled Nursing Facility</b> (Convalescent Care within 14 days of a 3 day hospital stay)	80% after deductible Semiprivate room rate 90 days Calendar Year maximum
<b>Spinal Manipulations / Chiropractic</b> – Network Provider – Non- Network Provider	100% after \$50 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Acupuncture</b> – Network Provider – Non- Network Provider	100% after \$50 copayment 80% after deductible Combined limit of 10 visits per Calendar Year
<b>Surgical Sterilization –</b> Male and Female	80% (deductible waived)
<b>Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)</b>	
Emergency or illness care	100% after \$50 copayment
<b>All other Eligible Expenses</b>	80% after deductible

**PRESCRIPTION DRUG BENEFIT – ALL PLANS**

**Prescription Drug Coverage - \$1,500 Calendar Year Out-Of-Pocket Maximum**

**Pharmacy Option – WellDyneRx (34-day supply)**

Generic drugs .....	\$5 + 20% Co-Insurance
Preferred drugs .....	\$20 + 20% Co-Insurance
Non-Preferred drugs .....	\$30 + 50% Co-Insurance

**Mail Order Prescription Drug Option - WellDyneRx (90-day supply)**

Generic drugs .....	\$5 + 20% Co-Insurance
Preferred drugs .....	\$20 + 20% Co-Insurance
Non-Preferred drugs .....	\$30 + 50% Co-Insurance

**NOTE:** Birth control pills are available through either a Retail or Mail Order pharmacy. Injectable drugs (including Growth Hormones, Immunosuppressant, AZT and Retrovere) are also available through the mail order prescription service. A starter dose will be available through Retail for 34 days. This provision allows Mail Order setup for future dispensing of injectable drugs. Certain Over-the-Counter (OTC) drugs are available for \$0 copayment or a discounted pharmacy rate, with a written Prescription. See Plan Document for additional information.

**Over-the-Counter (OTC) Drugs**

With a written prescription OTC stomach acid reducing medication and non-sedating antihistamine is available at \$0 co-pay. To receive the \$0 co-pay:

1. Ask your physician to write a 34 day supply prescription with refills for the OTC equivalent drug (OTC Prilosec, OTC Omeprazole, OTC Prevacid, OTC Zegerid, OTC Claritin D, OTC Alavert, OTC Loratadine, OTC Zyrtec D, OTC Cetirizine).
2. Get the OTC product from the store shelf and take it to the pharmacy.
3. Present the pharmacist with the OTC prescription from your physician, the product from the store shelf, and your ID card.

If an individual is prescribed a Preferred/Brand or Non-Preferred/Brand medication, and a generic is available, the individual must take the generic medication. If the individual chooses to take the Preferred/Brand or Non-Preferred/Brand medication, the individual will be responsible for paying the Preferred/Brand or Non-Preferred/Brand copayment, plus the difference in cost between the generic and Preferred/Brand or Non-Preferred/Brand medication.

## **Specialty Drugs**

Specialty drugs are limited to 2 fills through a retail pharmacy. After the second fill at the retail pharmacy, Specialty drugs must be filled through US Specialty Care (USSC), a division of WellDyneRx. Through US Specialty Care, you will receive convenient one-stop access to all specialty drugs, disease and drug education, compliance monitoring, proactive refill reminders and personalized care management programs designed to make therapy more effective.

Members are notified in writing after the second retail fill of a specialty drug, and provided direction for future fills. To avoid interruption in care, please call USSC at 1-800-641-8475 to get enrolled in the specialty drug program approximately 2 weeks prior to needing medication.

## **Out of network pharmacies**

Through WellDyneRx members have access to over 60,000 retail pharmacies nationwide. If a member goes to a contracted pharmacy without their ID card, they can submit a claim form for reimbursement that will be at the negotiated discount rate minus the co-pay. There is no coverage if a member purchases from a non-contracted pharmacy.

## **Discounted drugs**

With a written prescription members may purchase certain prescription and OTC smoking cessation (i.e. Chantix, Nicotrol, Nicorette, etc.) and weight loss drugs (i.e. Phentermine, Alli, Xenical, etc.) at the pharmacy discount rate. The discount will vary from drug to drug, and pharmacy to pharmacy. For additional information please contact WellDyneRx Member Services at 888-479-2000.

## MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

### DEDUCTIBLE/COPAYMENT

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible accrues toward the Out-Of-Pocket 100% maximum payment.

**Copayments.** A copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

**Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Deductible For A Common Accident.** This provision applies when 2 or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

### BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

### OUT-OF-POCKET LIMIT

Covered charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

## COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse. **There is no coverage of Pregnancy for a Dependent child.**

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

Expenses for **amniocentesis testing and genetic counseling** when recommended by a Physician for a Covered Person who is 35 years of age or older at the time of delivery, or for a documented high-risk pregnancy.

Prenatal diagnostic lab testing and birthing supplies when **ordered by a licensed or registered Midwife** for home births.

**Fetal surgery** will be considered as part of the mother's care.

**Licensed birthing centers.**

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
  - (a) the patient is confined as a bed patient in the facility; and
  - (b) the confinement starts within 14 days of a Hospital confinement as a registered bed patient of at least 3 days; and
  - (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

- (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by 1 surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

If multiple unrelated surgical procedures are performed by 2 or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If 2 or more surgeons perform a procedure that is normally performed by 1 surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure. and;

- (b) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20%, or a physician's assistant will not exceed 15% of the surgeon's Usual and Reasonable allowance.

- (5) **Inpatient Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Outpatient private duty nursing is not covered.

Charges for Inpatient Private Duty Nursing Care are subject to the limits as described in the Schedule of Benefits.

- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or 4 hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than 6 months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent). Bereavement services must be furnished within 3 months after the patient's death.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
- (a) **Acupuncture.** Charges for Acupuncture as described in the Schedule of Benefits.
  - (b) **Allergy testing,** treatment and injections. RAST (radioallergosorbent test) allergy testing will be allowed only when Medically Necessary as the only alternative to traditional allergy testing.
  - (c) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
  - (d) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
  - (e) **Assistant Surgeon's** fee when the procedure requires an assistant surgeon due to medical necessity.
  - (f) **Birth Control** pills, injections, implants, devices or other contraceptive methods, including insertion and removal of devices or implants.
  - (g) **Blood transfusions,** blood processing costs, blood transport charges, blood handling charges, administration charges, the cost of blood, plasma and blood derivatives and pre-surgical autologous storage of blood. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total of eligible covered expenses.

- (h) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (i) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included as are oral and prescription chemotherapy drugs.
- (j) **Cleft Palate and Cleft Lip.** The Plan will provide benefits for cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close.

The Plan will cover expenses incurred for the following services when provided by a Physician, other professional provider, and facilities necessary for treatment.

- (i) Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.
  - (ii) Habilitative speech therapy.
  - (iii) Otolaryngology treatment.
  - (iv) Audiological assessments and treatment.
  - (v) Orthodontic treatment.
  - (vi) Prosthodontic treatment.
  - (vii) Prosthetic treatment such as obturators, speech appliances and feeding appliances.
- (k) Initial **contact lenses or glasses** required following cataract surgery.
  - (l) **Diabetes Education and Training.** Charges for outpatient self-management training and education for diabetes are covered if prescribed by a health care professional. Outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. Covered outpatient self-management training and education shall be limited to a one-time evaluation and training program when medically necessary within one (1) year of diagnosis. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition or treatment.
  - (m) Injuries resulting from an act of **domestic violence**.
  - (n) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

- (o) **Education**, training and counseling (excluding materials) are a covered benefit for a medical diagnosis, except as indicated in the Exclusions section of this Plan.
- (p) **Hearing aids** and related services will be covered for Dependent Children only.
- (q) Expenses for treatment of kidney disorder by **hemodialysis or peritoneal dialysis** as an inpatient in a hospital or other facility, or for expenses in an outpatient facility or in your home, including the training of one (1) attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in your home.
- (r) Care, supplies and services for the diagnosis of **infertility**.
- (s) **Insulin** related supplies, including syringes.
- (t) Medically Necessary services (except for surgery) for care and treatment of **jaw joint conditions**, including Temporomandibular Joint syndrome (TMJ).

Charges for TMJ are subject to the limits as described in the Schedule of Benefits.

- (u) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.
- (v) Treatment of **Mental Disorders and Substance Abuse.** For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (w) Medically necessary **Morbid Obesity surgery.** Complications of Morbid Obesity surgery are not covered. Pre and post surgery are covered, subject to medical necessity and precertification. (Expenses for treatment, supplies, instruction or activities for weight reduction or physical fitness even if the services are performed or prescribed by a Physician are not covered).

- (x) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth. (with the exception of injuries incurred while chewing). Treatment must begin within 90 days of the accident and be completed within 12 months of the date of the accident.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of completely or partially impacted teeth.

Hospital expenses incurred for dental treatment are covered when confinement is medically necessary for such treatment, and charges for the anesthetics and their administration during such treatment are also covered.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (y) **Occupational therapy**. (Subject to the Rehabilitation Lifetime Plan Maximum Benefit as show in the Schedule of Benefits.) Treatment must be performed by a licensed Occupational Therapist. Therapy must result from an Injury or Sickness with the intent to improve body function. Covered Charges do not include recreational programs (i.e. personal trainer, health club membership, etc.), maintenance therapy or supplies used in occupational therapy.

- (z) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor.

- (aa) **Pain Clinics.** Covered charges for services received at a pain clinic.
- (bb) **Physical therapy** by a licensed Physical Therapist (subject to the Rehabilitation Lifetime Plan Maximum Benefit as shown in the Schedule of Benefits). The physical therapy must be in accord with a licensed Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through prescribed physical therapy.
- (cc) **Physician's assistant fee** when the procedure requires a Physician's assistant due to medical necessity, in lieu of the service of an assistant surgeon.
- (dd) **Preadmission Testing.** Expenses for preadmission testing for a covered surgery.
- (ee) **Prescription Drugs** (as defined).
- (ff) **Routine Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:
  - Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
  - Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
  - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives, sterilization procedures, and counseling.
    - Breastfeeding support, supplies, and counseling.
    - Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html). and

- [www.cdc.gov/vaccines/recs/acip/](http://www.cdc.gov/vaccines/recs/acip/)

Charges for **Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

- Diphtheria,
- Pertussis,
- Tetanus,
- Polio,
- Measles,
- Mumps,
- Rubella,
- Hemophilus influenza b (Hib),
- Hepatitis B,
- Varicella.

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html). and
- [www.cdc.gov/vaccines/recs/acip/](http://www.cdc.gov/vaccines/recs/acip/)

**(gg)** The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

**(hh)** **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i)** reconstruction of the breast on which a mastectomy has been performed,
- (ii)** surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii)** coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

**(ii)** **Rehabilitation Center**. Expenses for a Covered Person incurred for a sickness or injury that results in rehabilitation services are provided or

offered in a rehabilitation hospital or center and are covered up to the maximum shown in the Schedule of Benefits. The Covered Person must be under the care of a physician. Services may include Occupation, Physical and Speech Therapy.

Rehabilitation services mean a formal program of treatment that:

- (i) is provided for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative surgery.
- (ii) is performed in a rehabilitation hospital or center either as an inpatient or an outpatient;
- (iii) is prescribed by a physician as medically necessary and is periodically reviewed; and
- (iv) is prescribed in place of a stay in the acute setting of a hospital or is an extension of a hospital stay; and
- (v) is provided in a hospital or facility that is licensed and qualified to render rehabilitation services.

Covered expenses are charges, not to exceed the Usual and Reasonable Charges that are made for physical, speech and occupation therapy services.

Alcohol and drug rehabilitation expenses are not covered under this benefit.

- (jj) **Second and Third Surgical Opinion.** Second opinion surgical charges are covered. If the second surgeon disagrees with the recommendation of your physician, a third surgical opinion will be covered.
- (kk) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (ll) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C., subject to the Calendar Year maximum as described in the Schedule of Benefits.
- (mm) **Sterilization** procedures. Services for voluntary sterilization for participants and dependent spouses are covered. Reversals of vasectomies or tubal ligation are not covered.
- (nn) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

- (oo) Expenses incurred while **traveling outside the United States** on business or pleasure. Expenses incurred outside the United States, if the covered person traveled to such location for the primary purpose of obtaining medical services, drugs, or supplies, are not covered.
- (pp) **Urgent Care Facility.** Services and supplies offered by an Urgent Care Facility.
- (qq) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for **Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first 14 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for **Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for routine pediatric care for the first 14 days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (rr) Diagnostic **X-rays.** Covered as described in the Schedule of Benefits.

## **COST MANAGEMENT SERVICES**

### **Cost Management Services Phone Number**

CNIC Health Solutions, Inc.  
(800) 426-7453 or (303) 770-5710

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 2 days in advance of services being rendered or within 1 business day after a Medical Emergency.

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

### **UTILIZATION REVIEW**

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
  - **Inpatient Hospitalizations**
  - **Inpatient Hospice Care**
  - **Inpatient Rehabilitation**
  - **Outpatient Infusion, Chemotherapy and Radiation therapy (no pre-certification penalty applies to Chemo or Radiation therapy)**
  - **Clinical Trials**
  - **Outpatient Surgical procedures not performed in a physician's office, except for routine colonoscopies**
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

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

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

**Here's how the program works.**

**Precertification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator, CNIC Health Solutions, Inc., at (800) 426-7453 or (303) 770-5710 **at least 2 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact CNIC Health Solutions, Inc. **24 hours or 1 business day** after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

**If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$200.**

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

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

## **DISEASE MANAGEMENT**

**The following benefits for diagnosis of Diabetes and Heart Disease are available based on prior authorization by the Wellness nurse.**

**Diabetes: In order to access the diabetes management benefit, a diagnosis of diabetes must be made by a physician.**

The following services to be covered at 100%:

- Physician appointments and associated lab work
- Annual eye examination
- Annual foot examination
- Glucometers and supplies

Additional benefits covered at 100% up to a plan year maximum of \$500:

- Diabetic education program
- Nutritional counseling
- Smoking cessation therapy (counseling or medication – over the counter and/or prescribed)

Copayments for insulin and other medications to treat diabetes will be waived if there is prior authorization by the Wellness nurse.

**Member must participate in disease management program and be compliant with treatment plan in order to obtain the enhanced benefits.**

**Heart Disease: In order to access the heart disease management benefit, a diagnosis of heart disease (includes hypertension and elevated cholesterol) must be made by a physician.**

The following services to be covered at 100%:

- Physician appointments and associated lab work

Additional benefits covered at 100% up to a plan year maximum of \$500:

- Heart health education program
- Nutrition therapy
- Smoking cessation therapy (counseling or medication – over the counter and/or prescribed)

Copayments for medications to treat/prevent heart disease (includes cholesterol and blood pressure medications) will be waived if there is prior authorization by the Wellness nurse.

**Member must participate in disease management program and be compliant with treatment plan in order to obtain the enhanced benefits.**

## **SECOND AND/OR THIRD OPINION PROGRAM**

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

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

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

The patient may contact CNIC Health Solutions, Inc. for a referral or choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. CNIC Health Solutions, Inc. may at any time require a second or third opinion.

## **CENTERS OF EXCELLENCE PROGRAM**

Please note that as part of the Employee Benefit Plan, Covered Persons have access to a Centers of Excellence Program. This is a voluntary program which allows the Covered Person to use one of several facilities throughout the country that offer the highest quality care at a discounted rate for major procedures such as transplants, heart surgery, etc. For more information, contact the Precertification Department at CNIC Health Solutions, Inc. at (303) 770-5710 or (800) 426-7453.

## **PREADMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within 7 days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

## **OUTPATIENT SURGERY**

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

## **CASE MANAGEMENT**

**Case Management.** The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

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

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

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

The Plan reserves the right to allow for care at home or other alternative methods of treatment or medical care not otherwise covered under the Plan. In cases where the patient's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care, provided such care is approved by the Plan's case management organization, the patient (or patient's legal representative), the attending Physician and the Plan Administrator.

Benefits provided under this section are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

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

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

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

**Outpatient Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

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

**Brand Name** means a trade name medication.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

**Cosmetic Procedure/Surgery** means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function. Cosmetic procedures performed for psychiatric or psychological reasons or to change family characteristics or conditions due to aging are not covered under the Plan.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Covered Person** is an Employee, Retiree, Mayor, City Council member or their Dependent who is covered under this Plan.

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

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

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 90 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

**Custodial Care** is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

**Employer** is City of Casper.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**Essential Health Benefits** include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Formulary** means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

**Foster Child** means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Generic** drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least 2 unrelated persons who are expected to die within 6 months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Infertility** means incapable of producing offspring.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least 2 beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Laboratory, Pathology Services, X-ray and Radiology Services** are defined as Laboratory and pathology services – testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs); X-ray and radiology services – services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medical Non-Emergency Care** means care which can safely and adequately be provided other than in a Hospital.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claims Administrator shall make the initial determination whether care or treatment is Medically Necessary, within the Plan requirements, but the Plan Administrator has the final and ultimate discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Non-Network Provider** means a legally licensed health care provider which provides services and supplies within the scope of its authority, but which has not entered into a contract with the Preferred Provider Organization.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means City of Casper Employee Health Benefit Plan, which is a benefits plan for certain Employees, Retirees, Mayor and City Council members of City of Casper and is described in this document.

**Plan Participant** is any Employee, Retiree, Mayor, City Council member or their Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Preferred Provider Organization** means an independent entity which has developed a network of quality health care providers who contractually provide services and supplies, within the scope of their authority, on a reduced fee basis, to the Employees and Dependents of Employer sponsored health plans.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin;

hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Qualified Medical Child Support Order (QMCSO)** means a judgment, decree or order issued by a court; domestic relations magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act for Medicaid purposes). It requires that the child(ren) named in the order have the right to receive benefits from their parent through any group medical plan under which the parent is enrolled, whether or not the parent has family coverage. The required contribution for coverage will be that of family coverage. The QMCSO must contain:

- (1) the name and last known mailing address of the participant;
- (2) the name and mailing address of each child (alternate recipient) covered by the order;
- (3) a reasonable description of the type of coverage to be provided by the group health plan to each alternate recipient or the manner in which coverage will be determined;
- (4) the period of time to which the order applies; and
- (5) the identification of each plan to which the order applies.

**Restorative or Reconstructive Surgery** means surgery to restore or improve bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect.

**Retired Employee** is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

**Schedule of Benefits** means the outline of benefits.

**Second Surgical Opinion** means expenses incurred for examinations, x-rays, and lab performed by a qualified physician in the approved specialty to substantiate medical necessity of the procedure to be performed. A third opinion will be paid in case of a conflict between the first 2 opinions.

**Semiprivate** refers to a class of accommodations in a hospital or convalescent nursing facility in which at least 2 patient beds are available per room.

**Sickness** is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Sound Natural Teeth** means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.

**Specialty Medications:** Specialty medications are generally prescribed for people with complex or ongoing medical conditions to include but not limited to cancer, Crohn's disease, HIV, multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost medications also have one or more of the following characteristics: injected or infused, but some may be taken by mouth; unique storage or shipment requirements; additional education and support required from a health care professional; and usually not stocked at retail pharmacies. Please note that as new medications having similar indications enter the market, they may be added to the specialty drug program without notice.

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

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

**Total Disability (Totally Disabled)** means the physical state of a Covered Person resulting from an Illness or Injury which wholly prevents that individual from performing the duties pertaining to his/her customary employment. That individual must be under the continuous care of a Physician. All determinations of a final definition of a disability are the decision of the Plan Administrator. In the case of a Dependent, Total Disability (Totally Disabled) means unable to perform the normal activities of a person of same age and sex in good health. The Dependent must be under the continuous care of a Physician.

**Urgent Care Facility** means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A Physician and registered nurse (RN) must be in attendance at all times. The facility may or may not have an X-ray technician and X-ray and laboratory equipment. The facility must have a life support system available.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

**Waiting Period** means the period of time that must pass before an Employee or Dependent is eligible to enroll under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment is not a Waiting Period.

**Well Baby Care** means medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

**You, Your** means any Covered Person, unless the language specifically refers only to the Employee or only to the Dependents.

## PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. Dependent children are covered only if the Pregnancy is the result of rape or incest.
- (2) **Adoption.** Expenses not covered include, but are not limited to court costs, expenses related to the natural mother and expenses for the child prior to placement for adoption.
- (3) **Ambulance for convenience.** Any expense for commercial transport, private aviation, or air taxi services are not covered regardless of the circumstances or their FAA certification. Any expenses for transportation by private automobile, commercial or public transportation are not covered. The Plan will not pay for any of these services even if other means of transportation were not available.
- (4) **Artificial insemination,** including but not limited to invitro fertilization, GIFT procedure, surrogate parents, or expenses related to other direct attempts to induce pregnancy including drug and hormone therapy.
- (5) **Biofeedback.**
- (6) **Birthing classes.** Expenses for birthing classes.
- (7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered. **Complications of Morbid Obesity Surgery are not covered under this Plan.**
- (8) **Convenience.** Expenses required only for the convenience of the Covered Person or the Covered Person's Physician are not covered.
- (9) **Cosmetic surgery.** Any expenses for cosmetic services or the revision of a previous procedure performed for cosmetic purposes, including but not limited to, breast augmentation unless due to symmetrical reconstruction as provided under the reconstructive surgery benefit, are not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly or an accidental injury.

- (10) **Court order.** Any expenses incurred as a result of a court order, unless the expenses for the Illness or Injury would be covered under the Plan in the absence of a court order.
- (11) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (12) **Deluxe or luxury items** are not covered. Examples are motorized equipment when manually operated equipment can be used, wheelchair sidecars. The Plan will cover deluxe equipment only when additional features are required for effective medical treatment, or to allow the covered person to operate the equipment without assistance. Air conditioners, purifiers, humidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds or other floatation mattresses, self-help devices and other clothing and equipment which is not medical in nature are not covered, regardless of the relief they provide for a Medical Condition.
- (13) **Domiciliary care.** Care provided in a residential institution, treatment center, half-way house or school because the Covered Person's own home arrangements are not appropriate, and consisting chiefly of room and board is not covered, even if therapy is included.
- (14) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (15) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (16) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.
- (17) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, eye therapy and routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (18) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (19) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (20) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by applicable law.

- (21) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (22) **Health club membership.**
- (23) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except for Dependent Children or except as may be covered under the well adult or well child sections of this Plan.
- (24) **Homeopathic or naturopathic** physicians are not covered regardless of the relief they may provide.
- (25) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (26) **Hypnosis** whether for medical or anesthesia purposes.
- (27) **Illegal Acts.** Treatment for injury or illness of the Covered Person incurred in connection with actions by the Covered Person which would constitute a felony crime under applicable law and for which the Covered Person is charged with a felony crime, whether or not the Covered Person is convicted.
- (28) **Infant formula.**
- (29) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.
- (30) **Late claims filing.** Expenses submitted for coverage more than 15 months after the date of service are not covered.
- (31) **Lifestyle and personal growth counseling.**
- (32) **Mailing or sales tax.**
- (33) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (34) **Massage therapy.**
- (35) **Missed appointments.**
- (36) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (37) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

- (38) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (39) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (40) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (41) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (42) **Morbid Obesity.** Charges for **complications** as a result of a covered surgery related to Morbid Obesity are not covered.
- (43) **Occupational, physical or speech therapy** services to maintain function at a level to which it has been restored, or when no further significant practical improvement can be expected.
- (44) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (45) **Orthognathic (Jaw) Surgery.** The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental injury or due to a congenital defect.
- (46) **Orthotics.** Charges in connection with orthotics.
- (47) **Outpatient Private Duty Nursing.** Charges in connection with care, treatment or services of a Private Duty Nurse.
- (48) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (49) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (50) **Post-mortem testing.**
- (51) **Pregnancy of Dependent other than Spouse.** Care and treatment of Pregnancy and Complications of Pregnancy for a Covered Dependent other than a Covered Spouse.

- (52) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (53) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (54) **Rhinoplasty, blepharoplasty or brow lift** except expenses for rhinoplasties and blepharoplasties to correct a functional condition, or expenses for rhinoplasty to correct a condition as a result of an accidental injury.
- (55) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.
- (56) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (57) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (58) **Sleep disorders.** Testing, care and treatment for sleep disorders unless deemed Medically Necessary.
- (59) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches except as required by law under the Patient Protection Affordable Care Act (PPACA).
- (60) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (61) **Temporomandibular Joint Syndrome:** Charges for the surgery of Temporomandibular Joint Syndrome (TMJ) will not be a covered benefit under this Plan. Non-Surgical treatment for TMJ is covered pursuant to the Schedule of Benefits.
- (62) **Therapy and training** and self-help programs treatment, testing, procedures, devices and drugs, including but not limited to:
- (a) Any type of goal-oriented or behavior modification therapy.
  - (b) Holistic medicine, environmental medicine and naturopathic medicine.
  - (c) Megavitamin therapy.
  - (d) Myotherapy.
  - (e) Recreational, sex addiction, primal scream and Z therapies.

- (f) Religious or marital counseling.
- (g) Rolfing.
- (h) Self-help, stress management and weight loss programs.
- (i) Sensitivity or assertiveness training.
- (j) Transactional analysis, encounter groups and transcendental meditation.

**(63) Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

**(64) War.** Any loss that is due to a declared or undeclared act of war.

## **PRESCRIPTION DRUG BENEFITS**

### **Pharmacy Drug Charge**

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. WellDyneRx is the administrator of the pharmacy drug plan.

Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). For more detailed information, please contact WellDyneRx at (888) 479-2000 or [www.welldynernx.com](http://www.welldynernx.com).

### **Copayments**

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 34-day supply. Any one mail order prescription is limited to a 90-day supply.

### **Percentages Payable**

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

### **Over-the-counter (OTC) Drugs**

With a written prescription OTC stomach acid reducing medication and non-sedating antihistamine is available at \$0 co-pay. To receive the \$0 co-pay:

- (1) Ask your physician to write a 34 day supply prescription with refills for the OTC equivalent drug (OTC Prilosec, OTC Omeprazole, OTC Prevacid, OTC Claritin D, OTC Alavert, OTC Loratadine, OTC Zyrtec D, OTC Cetirizine)
- (2) Get the OTC product from the store shelf and take it to the pharmacy.
- (3) Present the pharmacist with the OTC prescription from your physician, the product from the store shelf, and your ID card.

If an individual is prescribed a Preferred/Brand or Non-Preferred/Brand medication, and a generic is available, the individual must take the generic medication. If the individual chooses to take the Preferred/Brand or Non-Preferred/Brand medication, the individual will be responsible for paying the Preferred/Brand or Non-Preferred/Brand copayment, plus the difference in cost between the generic and Preferred/Brand or Non-Preferred/Brand medication.

## **Specialty Drugs**

Specialty drugs are limited to 2 fills through a retail pharmacy. After the second fill at the retail pharmacy, Specialty drugs must be filled through US Specialty Care (USSC), a division of WellDyneRx. Through US Specialty Care, you will receive convenient one-stop access to all specialty drugs, disease and drug education, compliance monitoring, proactive refill reminders and personalized care management programs designed to make therapy more effective.

Members are notified in writing after the second retail fill of a specialty drug, and provided direction for future fills. To avoid interruption in care, please call USSC at 1-800-641-8475 to get enrolled in the specialty drug program approximately 2 weeks prior to needing medication.

## **Out of network pharmacies**

Through WellDyneRx members have access to over 60,000 retail pharmacies nationwide. If a member goes to a contracted pharmacy without their ID card, they can submit a claim form for reimbursement that will be at the negotiated discount rate minus the co-pay. There is no coverage if a member purchases from a non-contracted pharmacy.

## **Discounted drugs**

With a written prescription members may purchase certain prescription and Over The Counter (OTC) smoking cessation (i.e. Chantix, Nicotrol, Nicorette, etc.) and weight loss drugs (i.e. Phentermine, Alli, Xenical, etc.) at the pharmacy discount rate. The discount will vary from drug to drug, and pharmacy to pharmacy. For additional information please contact WellDyneRx Member Services at 888-479-2000.

## **Mail Order Drug Benefit Option**

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, WellDyneRx, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

## **Covered Prescription Drugs**

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.
- (4) Injectable drugs or any prescription directing administration by injection.

- (5) Impotence medication.
- (6) Growth hormones.
- (7) Corowise is covered as a generic.

### **Limits To This Benefit**

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any 1 prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to 1 year from the date of order by a Physician.

### **Expenses Not Covered**

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Immunization.** Immunization agents or biological sera.
- (9) **Infertility.** A charge for infertility medication.
- (10) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

- (11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (15) **Refills.** Any refill that is requested more than 1 year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (16) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, except as required by law under the Patient Protection Affordable Care Act (PPACA).
- (17) **Weight Loss Drugs.** A charge for Prescription Drugs for any type of Weight Loss is not a covered benefit.

## HOW TO SUBMIT A CLAIM

**Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.**

When a Covered Person has a claim to submit for payment, either the Employee or Provider should submit bills for services rendered.

### **ALL BILLS MUST SHOW:**

Name of Plan: **City of Casper Employee Health Benefit Plan**  
Employee's name  
Name, address, telephone number and tax ID number of provider of care  
Diagnosis  
Type of services rendered, with diagnosis and/or procedure codes  
Date of Services  
Charges  
Group # **11101140**

Send the above to the Claims Administrator at this address:

CNIC Health Solutions, Inc.  
P. O. Box 76149  
Colorado Springs, Colorado 80970  
(877) 321-4412 or (719) 622-3300

The claims administrator reserves the right to routinely request employment and/or other insurance information from the covered Employee/Spouse. These requests will be submitted in writing to the Employee. Claims payment may be pended until details are disclosed and submitted in writing to the Claims Administrator.

### **WHEN CLAIMS SHOULD BE FILED**

Claims should be filed with the Claims Administrator within ninety (90) days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within fifteen (15) months from the date incurred. This 15-month period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## **CLAIMS PROCEDURE**

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. The initial adverse benefit determination, and the first level of appeal, will be processed by the Claims Administrator pursuant to the terms and conditions of the Plan and any additional guidance provided by the Plan Administrator relevant to the Claim. If the claimant receives an adverse benefit determination from the first level of appeal issued by the Claims Administrator (CNIC), the claimant may make a final internal written appeal to the Plan Administrator (City of Casper). If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim pursuant to the terms of the Plan. The notification to the claimant of the decision must be made as soon as practical and not later than the time shown in the timetable by the Claims Administrator. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan, the claimant may be notified that the period for providing the notification will

need to be extended. If the period is extended because more information is needed from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, a decision must be made as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Appeal must be decided and, if the Appeal is denied, notice must be provided to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

**Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including benefit determination on review, may be transmitted between the Claims Administrator and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

### **Concurrent Care Claims**

A Concurrent Care Claim is a special type of Claim that arises if the Claims Administrator informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Claims Administrator will notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days

### **Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

### **Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

### **Notice to claimant of Adverse Benefit Determinations**

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, a written or electronic notification of the Adverse Benefit Determination shall be provided. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- (1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.
- (2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.
- (3) Reference to the specific Plan provisions on which the determination was based.
- (4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.
- (6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.
- (7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- (8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

## **Appeals**

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records and other information relating to the Claim.

A Claimant must mail the initial appeal to:

CN IC Health Solutions, Inc.  
P.O. Box 3559  
Englewood, Colorado 80155-3559  
(303) 770-5710 or (800) 426-7453

If the claimant receives an adverse benefit determination from the initial appeal process, the claimant may make a written appeal to the City of Casper Health Plan Appeals Committee ("Committee") by forwarding a written response to the initial appeal via mail within the above prescribed timelines to:

The City of Casper  
Health Plan Appeals Committee c/o: Human Resources  
200 N. David St. Casper, WY 82601

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated. This evidence shall be provided free of charge.

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

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

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

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The

review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. The Claims Administrator (CNIC) is not a fiduciary of the Plan.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall ensure that a written notification of the Adverse Benefit Determination on Appeal is provided by the Claims Administrator. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- (1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.
- (2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.
- (3) Reference to the specific Plan provisions on which the determination was based.
- (4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.
- (6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- (9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

### **EXTERNAL REVIEW PROCESS**

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Claims Administrator will determine whether the Claim is eligible for review under the External Review process pursuant to the terms of the Plan. The preliminary review will be completed within five business days. This determination is based on the criteria described above and whether:

- (1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;
- (2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;
- (3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and
- (4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Claim Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Claims Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan by coordinating with the Claims Administrator. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- (1) The claimant's medical records;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;
- (4) The terms of the Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the Plan; and
- (7) The opinion of the IRO 's clinical reviewer.

The IRQ must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

- (1) A general description of the reason for the External Review, including information sufficient to identify the claim;
- (2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (3) References to the evidence or documentation the IRO considered in reaching its decision;
- (4) A discussion of the principal reason(s) for the IRO 's decision;
- (5) A statement that the determination is binding and that judicial review may be available to the claimant; and

- (6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

- (1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
- (2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and ensure notification is made to the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when 2 or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under 2 or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

**Benefit plan.** This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable Charge.** For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

**Automobile Limitations.** When medical payments are available under vehicle insurance, the Plan shall have no liability for expenses covered by any other available vehicle coverage, regardless of whether under a no-fault or tort-based system. The Plan shall **pay excess coverage only**, without reimbursement for vehicle plan deductibles. Please refer to the Schedule of Benefits for specific coverage information. This Plan shall always be considered the secondary when other coverage is available.

For expenses resulting from an automobile accident such coverage carried through auto insurance carriers, which will be considered primary, includes but is not limited to:

- No-Fault Personal Injury Protection (PIP);
- Optional Medical Payments Coverage (MPC);
- Bodily injury liability coverage;
- Un-insured or under-insured motorist coverage; or
- Personal liability umbrella policies, which include excess benefits for medical expenses related to automobile accidents.

Auto related claims that are the responsibility of a third party are also subject to the Third Party Recovery Provision section of the Plan.

**Benefit plan payment order.** When 2 or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
  - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
  - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
  - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
    - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;



- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a state Child Health Insurance Plan to the extent required by federal law.

**Claims determination period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

**Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

## **THIRD PARTY RECOVERY PROVISION**

### **RIGHT OF SUBROGATION AND REFUND**

**When this provision applies.** The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

**Amount subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated

with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:** "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is City of Casper, 200 North David, Casper, Wyoming, 82601, (307) 235-8228. COBRA continuation coverage for the Plan is administered by GBS. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even in the event of a failure to pay the required premiums for coverage under the Plan during the FMLA leave by the Employee and family members or on behalf of the Employee and family members.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Second, if you do not elect COBRA continuation coverage and ensure payment of the appropriate premiums for the maximum time available to you is made, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his

right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the 6 months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 31 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer,  
or
- (4) entitlement of the employee to any part of Medicare.

#### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 63 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.**

### **NOTICE PROCEDURES:**

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

GBS Benefits, Inc.  
465 South, 400 East, Suite 300  
Salt lake City, Utah 84111

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

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

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

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

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

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

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

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

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

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

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

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

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

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

**Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

#### **IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

#### **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

**PLAN ADMINISTRATOR.** City of Casper Employee Health Benefit Plan is the benefit plan of City of Casper, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by City of Casper to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Casper shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

### **DUTIES OF THE PLAN ADMINISTRATOR.**

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
  - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected

Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
- (iii) Mitigating any harm caused by the breach, to the extent practicable; and
- (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of City of Casper's workforce are designated as authorized to receive Protected Health Information from City of Casper Employee Health Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Manager of Human Resources.

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

## **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

### **CLERICAL ERROR**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

### **AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

## **GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded group Health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

**PLAN NAME:** City of Casper Employee Health Benefit Plan

**PLAN NUMBER:** 501

**TAX ID NUMBER:** 83-6000049

**PLAN EFFECTIVE DATE:** July 1, 1986

**PLAN RESTATEMENT DATE:** January 1, 2014

**PLAN YEAR ENDS:** December 31

### **EMPLOYER INFORMATION**

City of Casper  
200 North David  
Casper, Wyoming 82601  
(307) 235-8344

### **PLAN ADMINISTRATOR**

City of Casper  
200 North David  
Casper, Wyoming 82601  
(307) 235-8344

### **CLAIMS ADMINISTRATOR**

CNIC Health Solutions, Inc.  
P. O. Box 76149  
Colorado Springs, Colorado 80970  
(877) 321-4412 or (719) 622-3300