Plan Document
&
Summary Plan Description
for
Transit Authority of the City of Omaha, dba, METRO
Employee Benefit Plan

Group # 21020000

Revised and Effective: January 1, 2018

Mid-American Benefits, Inc.
5310 North 99th Street, Suite 1
Omaha, NE 68134

MID-AMERICAN BENEFITS, INC.
For all the right reasons!

Introduction

Transit Authority of the City of Omaha, dba, METRO (the "employer") is pleased to offer you medical, prescription drug, and dental plans. It is a valuable and important part of your overall compensation package.

This booklet describes your medical, prescription drug, and dental benefits and serves as the Plan Document and Summary Plan Description (SPD) for the Transit Authority of the City of Omaha, dba, METRO Employee Benefit Plan ("the Plan"). It sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. This is a self-funded, non-federal governmental benefit plan, coming within the purview of the State of Nebraska. The Plan is funded with employee and/or employer contributions. As such, when applicable, State law and jurisdiction preempt Federal law and jurisdiction.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep it in a safe and convenient place for future reference.

Table of Contents

Plan Overview

Your Eligibility

You are eligible for benefits if you:

- Are an active employee who normally works at least 30 hours per week;
- Are on the regular payroll of the employer;
- Are in a class of employees eligible for coverage; or
- As determined by the employer based on their implementation of the PPACA Employer Shared Responsibility guidelines and regulations

The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, leasing organization, contract employees, and other individuals who are not on the employer's payroll, as determined by the employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents of Employees

Employees may enroll their eligible dependents on their coverage. Your eligible dependents include:

- Your legal spouse (as determined by Federal law)
- Your child under age 26 regardless of financial dependency, residency with you, marital status, student status, or their eligibility for coverage with their own or their spouse's employer
- Your unmarried child of any age who is not capable of self-support due to a physical or mental disability or disorder that occurred before age 26 whose disability is continuous and who is incapable of self-sustaining employment and is principally supported by you. Application for extended coverage must be made within 31 days of the date your child reaches the applicable age limit. After initial proof, the claims administrator may request proof again two years later, and each year thereafter.
  Note: "Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.
  Note: Mental disorders exclude learning or attention deficit disorders.

For purposes of the Plan, your child includes:

- Your biological child
- Your legally adopted child (including any child under age 26 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support)
- A step child as long as you are married to the child's natural parent
- An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN)

An eligible dependent does not include:

- An individual enrolled as an employee under the Plan
- Any individual who is in active military services
- A former spouse
- A domestic partner
- An individual who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.
- A dependent that lives outside the United States unless the dependent has established his or her primary residence with you.
- A foster child
- A grandchild
- A dependent child's legal dependent
- A child of a domestic partner or a child under your domestic partner's legal guardianship
- Any other relative or individual unless explicitly covered by this Plan

It is your responsibility to notify the Plan Sponsor within 31 days if your dependent becomes ineligible for coverage.

Proof of Eligibility for Employee Dependents

The employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for a covered dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

For You

Your coverage begins on the first day of the calendar month following your completion of the Orientation Period and the Waiting Period and after you meet all eligibility requirements for coverage.

Orientation Period

The Orientation Period begins on the employee's date of hire and requires continuous active employment during the entire period. It is measured by adding one calendar month to the employee's date of hire and then subtracting one calendar day. If there is no corresponding date in the calendar month that immediately follows the month of the employee's date of hire, the last day of the Orientation Period will be the last day of the calendar month immediately following the month of the employee's date of hire.

The Orientation Period occurs separately and prior to the Waiting Period.

Example # 1: Employee date of hire is May 3rd, the Orientation Period ends on June 2nd.
Example # 2: Employee date of hire is October 1st, the Orientation Period ends on October 31st.
Example # 3: Employee date of hire is January 30th, the Orientation Period ends on February 28th (or February 29th in a leap year)

Waiting Period

The Waiting Period begins on the first calendar day after the Orientation Period ends.
The Waiting Period duration is 60 days of continuous active employment.
Example # 1: Employee Orientation Period ends on June 2nd. The Waiting Period begins on June 3rd.
Example # 2: Employee Orientation Period ends on October 31st. The Waiting Period begins on November 1st.
Example # 3: Employee Orientation Period ends on February 28th (or February 29th in a leap year). The Waiting Period begins on March 1st.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan. However, if you return to work and were enrolled in COBRA Continuation Coverage immediately prior to your rehire date, you will be covered under the Plan as of the first day of the calendar month following your rehire date and will not have to satisfy any Orientation Period or Waiting Period.

For Your Dependents

You must elect coverage for yourself in order to cover your eligible dependents.

If you enroll your eligible dependents within 31 days of your initial eligibility, their coverage begins at the same time as yours. If you wait longer than 31 days, the enrollment will be considered a late enrollment.

Your Contribution for Coverage

Both the employer and you share in the cost of your coverage. The level of any employee contributions is set by the Plan Administrator. The Plan Administrator will periodically communicate the employee contributions and reserves the right to change the level of contributions at any time. The actual cost for employees is determined by the coverage you select and the number of dependents you cover. When you enroll in the Plan, you authorize the employer to deduct any required premiums from your pay.

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials.

You will automatically receive an identification card for you and your eligible dependents once your enrollment is processed.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the plan cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following January 1 and stay in effect through December 31, unless you have a qualifying change due to a special enrollment as described in the **Special Enrollment Rights** in the Plan Document/Summary Plan Description.

Late Entrant

An enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a "late entrant" if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Late Entrants will only be accepted during the Annual Open Enrollment period for a January 1 effective date.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan without being considered a "late entrant" if you or your dependents lose eligibility for that other coverage or if the employer stopped contributing towards your or your dependents' other coverage. Coverage begins on the date following loss of coverage. You must request enrollment within 31 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

If you have a new dependent as a result of marriage, adoption, placement for adoption, or birth, you may be able to enroll yourself and your dependents.

- Coverage for newly eligible dependents, such as marriage or adoption, will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible.
- Newborn children of a covered employee will not be automatically enrolled in the Plan. Coverage will be effective with the newborn's date of birth, provided the child is enrolled within 31 days of birth. Charges for a well newborn's initial routine nursery care will be covered under the Plan of the covered parent. For coverage beyond the initial routine hospitalization, a written request for coverage must be received by the claims administrator within 31 days from the date of birth.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. Coverage begins on the date the approved request for coverage is received. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

You or your dependents may not enroll for coverage under this Plan due to loss of coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact; or
- You or your dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

When Coverage Ends

Your coverage under this Plan ends on the last day of the calendar month in which your employment terminates, you cease to be an eligible employee, or you request termination of coverage for you and/or your covered dependents.

Coverage for covered dependents ends when your coverage ends or, if earlier, on the last day of the calendar month in which your dependent is no longer eligible for coverage.

Coverage will also end for you and your covered dependents as of the date the employer terminates this Plan.

If you fail to remit any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled as of the end of the period for which payment has been made and no claims incurred after the effective date of cancellation will be paid.

If your coverage under the Plan ends for reasons other than the employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Rescission of Coverage

Coverage under the Plan may be rescinded retroactively if a participant performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

Coverage for your ex-spouse may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan.

Coverage will be rescinded prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by a participant. The participant will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from a participant any benefits paid as a result of the wrongful activities that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on the participant's behalf, continuation coverage under COBRA may be denied to the participant.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with your Human Resources Department what options are available for paying your share of costs while you are absent from work.

If You Are Absent Due to Total Disability, Approved Leave (non-FMLA) or Layoff

If you become totally disabled, take an approved leave of absence (paid or unpaid), or are laid off for a period of time, your coverage may continue for up to 90 days following the month in which your absence or layoff occurs, as long as you continue to pay your share of the cost.

If You Take a Leave of Absence - FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the employer's FMLA Policy.

If You Take a Leave of Absence - Military

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

If You Die

If you die while you are a covered employee, your surviving spouse and eligible dependents will be eligible for COBRA continuation coverage beginning with the month following your date of death.

Summary of Medical & Prescription Benefits

	In-Network Elite Choice Benefits	Out-of-Network		Limitations & Exceptions
Annual Calendar Year Maximum Paid Benefit Per Participant	**Unlimited** Except for certain services See Limitations & Exceptions			
Annual Calendar Year Deductible	$600.00 / individual $1,200.00 / family (Embedded)	$5,000.00 / individual $10,000.00 / family (Embedded)		Annual Deductible does not include: • Copayments • Any expenses not covered under the Plan • Penalties for failing to follow precertification procedures • Amounts in excess of the Maximum Allowable Charge
	Deductible Accumulation: Embedded • Each individual must meet the individual deductible before benefits are payable unless any combination of family members have satisfied the family deductible then the deductible is satisfied for all family members.			
Out-of-Pocket Maximum Includes Deductible	$2,000.00 / individual $4,000.00 / family (Embedded)	$10,000.00 / individual $20,000.00 / family (Embedded)		Out of Pocket Maximum does not include: • Any expenses not covered under the Plan • Penalties for failing to follow precertification procedures • Amounts in excess of the Maximum Allowable Charge
	Out-of-Pocket Accumulation: Embedded • Each individual must satisfy the individual Out-of-Pocket maximum unless any combination of family members have satisfied the family Out-of-Pocket maximum then the Out-of-Pocket maximum is satisfied for all family members.			

Service	In-Network Elite Choice	Out-of-Network		Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated** • **Limitations & Exceptions apply to In-Network and Out-of-Network benefits**				
Allergy Injections, Serums & Testing	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Ambulance Service	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Breast Pumps Manual	Plan pays 100% Deductible Waived	Plan pays 70% of Maximum Allowable Charge		
Chemotherapy / Radiation	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Diabetic Services	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Diabetes education is limited to $500.00 in a two-year period.
DiagnosticX-rays and Lab Services performed outside of physician's office Includes advanced radiological imaging	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• All Out-of-Network non-emergency MRI's and CAT scans need to be set up through and performed by a Care IQ Facility. If not done through a Care IQ Facility, an additional $200.00 copay applies.
Dialysis	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Durable Medical Equipment	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Rental up to purchase price
Emergency Care – Hospital Emergency Room	Plan pays 90% after $125.00 copay	Plan pays 90% of Maximum Allowable Charge after $125.00 copay Non-Emergency Services Plan pays 70% of Maximum Allowable Charge		• Copay is waived if admitted to hospital • Refer to the Plan Document for the definition of Emergency Care
Home Health Care	Plan pays 100%	Plan pays 100% of Maximum Allowable Charge		• Limited to 100 visits per calendar year
Hospice Care	Plan pays 100%	Plan pays 100% of Maximum Allowable Charge		
Hospital Services – Inpatient	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		

Service	In-Network Elite Choice	Out-of-Network		Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated** • **Limitations & Exceptions apply to In-Network and Out-of-Network benefits**				
Hospital Services – Outpatient Includes hospital outpatient physician visits	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Infertility Diagnosis	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Includes services for the diagnosis only
Mental Health Inpatient, Outpatient & Partial Hospitalization	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Physician / Professional Services Includes fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Physician Office Visit For injury or sickness including surgical fees, allergy testing, serum & injections, or other medical services and supplies performed in the office. Includes X-rays and lab work sent out of the physician's office for interpretation. Excludes preventive care.	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Pregnancy Services – For Inpatient / Birthing Center including services for labor and delivery	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Preventive Care	Plan pays 100% Deductible Waived	Plan pays 70% of Maximum Allowable Charge		
Prosthetics	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Skilled Nursing Facility	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Limited to 30 days per calendar year
Substance Abuse Inpatient, Outpatient & Partial Hospitalization	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Temporomandibular Joint Disorder (TMJ)	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Limited to $1,000.00 lifetime maximum benefit

Service	In-Network Elite Choice	Out-of-Network		Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated** • **Limitations & Exceptions apply to In-Network and Out-of-Network benefits**				
Therapy Services Cardiac & Pulmonary	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Limited to 18 visits per calendar year per therapy
Therapy Services Occupational, Physical, Speech, Chiropractic or Osteopathic Physiotherapy or Manipulative Treatments or Adjustments	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Limited to 60 visits per calendar year for any combination of these services
Transplants	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		
Urgent Care Center	Plan pays 100% after $40.00 copay Deductible Waived	Plan pays 100% of Maximum Allowable Charge after $40.00 copay Deductible Waived		• Copay is waived if admitted to hospital
Wig after Chemotherapy or Radiation	Plan pays 90%	Plan pays 70% of Maximum Allowable Charge		• Limited to $2,000.00 lifetime benefit

	You Pay	Plan Pays	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated**			
Retail Pharmacy (30 Day Supply) (participating pharmacy)			
Generic	20% copay ($7.50 minimum / $10.00 maximum. If prescription is less than $7.50, the copay is the cost of the prescription.) Deductible Waived	100% after copay	• If the physician or participant requests a Formulary Brand Name or a Non-Formulary Brand Name drug and a generic is available, the participant will pay 100% of the cost.
Formulary Brand Name Drugs	20% copay ($15.00 minimum / $25.00 maximum. If prescription is less than $15.00, the copay is the cost of the prescription.) Deductible Waived	100% after copay	
Non-Formulary Brand Name Drugs	20% copay ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copay is the cost of the prescription.) Deductible Waived	100% after copay	
Mail Order Prescription Drug Option (90 Day Supply)			
Generic	20% copay ($15.00 minimum / $20.00 maximum. If prescription is less than $15.00, the copay is the cost of the prescription.) Deductible Waived	100% after copay	• If the physician or participant requests a Formulary Brand Name or a Non-Formulary Brand Name drug and a generic is available, the participant will pay 100% of the cost. • Specialty Drugs must be purchased through Magellan Rx by calling 800-424-5828
Formulary Brand Name Drugs	20% copay ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copay is the cost of the prescription.) Deductible Waived	100% after copay	
Non-Formulary Brand Name Drugs	20% copay ($60.00 minimum / $100.00 maximum. If prescription is less than $60.00, the copay is the cost of the prescription.) Deductible Waived	100% after copay	
Specialty Drugs	Subject to deductible and coinsurance	90% after deductible	

	You Pay	Plan Pays	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated**			
Digestive Disorder Medications (heartburn/ulcer related drugs) (retail pharmacy) (30 day supply)			
Nizatidine (generic Axid) Famotidine (generic Pepcid) Omeprazole (generic Prilosec) Metoclopropamide (generic Regian) Cimetidine (generic Tagamet) Ranitidine (generic Zantac)	$7.50 copay Deductible Waived	100% after copay	
Aciphex Axid Nexium Prevacid Prilosec Protonix	$50.00 copay Deductible Waived	100% after copay	
Over the Counter Medications (30 day supply)			
Allergy/Antihistamines/Cold/Cough	$0.00 Deductible Waived	100%	Hy-Vee: Allergy Relief Series, OHM, All Day Allergy, Tussin Walgreens: Wal-itin, Wal-itin D, Wal-Zyr, Wal-tussin Walmart: Equate Allergy Relief, Allergy Relief 24 hour, Equate Allergy, Equate Tussin CF or DM
Heartburn / Acid Reflux	$0.00 Deductible Waived	100%	Pepcid AC, Zantac 74 150, Prilosec OTC, Tagamet HB, Axid AR, Wal-Zan

Summary of Dental Benefits

Annual Calendar Year Maximum Paid Benefit	$600.00 / individual
Annual Calendar Year Deductible	$25.00 individual / $75.00 family
Type A – Preventative & Diagnostic	Plan pays 100% of Maximum Allowable Charge Deductible Waived
Type B – Maintenance	Plan pays 80% of Maximum Allowable Charge after deductible
Type C – Major Restoration	Plan pays 50% of Maximum Allowable Charge after deductible

- This plan does not provide orthodontia or related services

PLAN DESIGN FEATURES & LIMITATIONS

Type A Services – Preventive & Diagnostic

- Oral exams (including problem focused) – 2 per calendar year paid at 100%
- Cleaning of teeth (oral prophylaxis) - 1 time in 6 months
- Topical fluoride treatment for a child under age 14 - 1 time in 12 months
- Sealants for a child under age 14, which are applied to non-restored, non-decayed first and second permanent molars - Once per tooth in 60 months
- Full mouth or panoramic X-rays – Once every 5 years paid at 100%
- Bitewing X-rays - 1 per calendar year paid at 100%

Type B Services - Basic

- Amalgam or Resin Composite filling replacements if at least 24 months have passed since the existing filling was placed or a new surface of decay is identified on that tooth.
- Space maintainers - Limited to one per lifetime per area for a child under 14 years of age

Type C Services – Major

- Crowns
- Dentures
- Extractions
- Periodontal
- Root canals

Medical Benefits

Assignment of Benefits

The Plan Administrator may revoke an assignment of benefits at its discretion and treat the participant as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the participant, the plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan, does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Network Provisions

Your medical benefits are delivered through a network of participating physicians, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

This type of network gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care In or Out-of-Network. Refer to the Summary of Medical Benefits chart for more information.

When you enroll in a Plan that uses a network of physicians, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

If you use In-Network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible, co-insurance, or co-pays). Generally, you will not be required to file a claim form when you receive In-Network benefits but in some cases, the provider or claims administrator may require you to do so.

If an In-Network provider refers x-ray or laboratory services to an Out-of-Network provider, those services will be paid at the In-Network level of benefits.

If you use Out-of-Network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible, co-insurance, or co-pays), up to the Maximum Allowable Charge. You are responsible for charges in excess of the Maximum Allowable Charge and this excess amount does not apply to your deductible or out-of-pocket maximum. You also pay a higher deductible and out-of-pocket maximum for using Out-of-Network providers, and you may be required to file claim forms. An explanation of Maximum Allowable Charge is provided below.

If you receive Out-of-Network professional services including, but not limited to, anesthesiology, radiology, emergency room physician services or pathology but rendered at an In-Network facility, those services will be paid at the In-Network level of benefits.

Maximum Allowable Charge Limit

If your Plan does not use a network of providers or you use Out-of-Network providers, covered medical expenses are subject to the Maximum Allowable Charge limit and you are responsible for paying any charges above this limit.

Deductible

A deductible is the amount you must pay for certain covered expenses in a calendar year before the Plan pays benefits. Consult the Summary of Medical Benefits chart for more information. The deductible will be applied to covered services based on the order that the charges are received.

Charges applied to the In-Network deductible do not cross accumulate to the Out-of-Network deductible and vice-versa.

Your deductible does not include:

- Copayments
- Any expenses not covered under the Plan
- Penalties for failing to follow precertification procedures
- Amounts in excess of Maximum Allowable Charge

Deductible Accumulation

Each individual must meet the individual deductible before benefits are payable unless any combination of family members have satisfied the family deductible, then the deductible is satisfied for all family members.

Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the deductible amount to any eligible expenses and to apportion the benefits to the participant and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the participant and all assignees.

Copayment

Certain services may require a copayment – a fixed dollar amount you must pay before the Plan pays for that service. The copayment applies regardless of whether the deductible has been met.

Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses and you may be responsible to pay a portion. The percentage you pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care In-Network, which means your percentage will be lower.

The amount of your coinsurance may depend upon the type of provider you see, where you receive services, and how you are billed for those services. The Summary of Medical Benefits chart shows the coinsurance levels for common medical services.

Out-of-Pocket Maximum

The out-of-pocket maximum limits your total portion of costs each calendar year. When your share of coinsurance for covered medical expenses reaches the out-of-pocket maximum, your coinsurance percentage becomes zero for the rest of the calendar year and the Plan pays 100% of covered medical expenses. There are separate individual and family out-of-pocket maximums, as shown in the Summary of Medical Benefits chart.

Charges applied to the In-Network Out-of-Pocket maximum do not cross accumulate to the Out-of-Network Out-of-Pocket maximum and vice-versa.

The out-of-pocket maximum does not include:

- Any expenses not covered under the Plan
- Penalties for failing to follow precertification procedures
- Amounts in excess of the Maximum Allowable Charge

Out-of-Pocket Accumulation

Each individual must satisfy the individual out-of-pocket maximum unless any combination of family members have satisfied the family out-of-pocket maximum, then the out-of-pocket maximum is satisfied for all family members.

Eligible Medical Expenses

Eligible expenses are for services and supplies that are approved by a physician or other appropriate covered provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Eligible expenses are limited to the Maximum Allowable Charge. If an expense is incurred from an In-Network provider, covered expenses will be the discounted amount and will not be subject to the Maximum Allowable Charge.

The following are common conditions for which expenses for services or supplies are typically paid:

- Allergy Treatment – includes allergy testing, treatment, injections and serum.
- Ambulance – medically necessary local professional ground or air ambulance services. A charge for this item will be a covered service only if the service is to the nearest facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was medically necessary. Emergency ambulance services will be paid at the In-Network provider level of benefits.
- Ambulatory Surgical Center – includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery.
- Anesthesia – includes anesthetics and the services of a physician or certified nurse anesthetist (C.R.N.A.)
- Blood – includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services. Processing, storage, and administration charges for autologous blood (patient's own blood) when a participant is scheduled for surgery that can be expected to require blood.
- Breast pumps – covered for manual breast pumps.
- Chemotherapy or Radiation – includes medically necessary and appropriate drugs and services of a physician or medical provider.
- Chiropractic Services / Spinal Manipulation – by a licensed M.D., D.O., or D.C.
- Clinical Trials (refer to definition page)
    - The Plan may require a qualified participant to use an In-Network provider for the approved clinical trial if that provider is a trial participant and will accept the patient.
    - The Plan does not cover items and services that are not routine patient costs, including, but not limited to:
        - ✓ The investigational item, device or service itself
        - ✓ Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient
        - ✓ Any service inconsistent with the established standard of care for the patient's diagnosis
- Contraceptives – charges for oral contraceptives (e.g. Ortho-Novum, Lo/Ovral, Seasonale), contraceptive patches (e.g. OrthoEvra), contraceptive vaginal rings (e.g. Nuva-Ring), contraceptive devices (e.g. diaphragms, IUD's), contraceptive injectables (e.g. Depo-Provera), and contraceptive implants (e.g. Norplant).
    - Prescription oral contraceptives and patches are covered under the prescription drug portion of the Plan.
    - All other types of covered prescription contraceptives are considered under the medical plan.
- Dental / Oral – charges for the following dental-related services are considered under the medical portion of the plan.
    - Emergency repair due to injury to sound natural teeth provided such treatment is received within six months of the date of injury
    - Excision of tumors and cysts of the jaws, jawbone, 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
- Oral surgery required by injury or accident
- Removal of impacted teeth
- Treatment of fractures and traumatic dislocations of the jawbone

- Diabetic Services - includes equipment and diabetes education provided by an approved program or certified diabetes educator, up to a maximum of $500.00 per participant in a two-year period. Benefits are available for self-management training and patient management, including nutrition therapy.
- Diagnostic Lab and X-Ray, Outpatient – includes laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and advanced imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by physicians throughout the United States.
- Dialysis Services – includes the services of an individual to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved provider.
- Durable Medical Equipment – includes coverage for the rental (or purchase, if rental would be more costly) of durable medical equipment required for therapeutic purposes, as prescribed by a covered provider and determined by the Plan to be medically necessary.

  Durable Medical Equipment includes, but is not limited to, such items as orthopedic braces, crutches, wheelchairs, oxygen and rental of equipment for the administration of oxygen.

  No coverage is provided for the repair, replacement or duplicates except when medically necessary because of a physiological change or to improve physical function.
- Emergency Room Visits – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care.
- Home Health Care - includes home health care services and supplies for care and treatment when hospital or skilled nursing facility confinement would otherwise be required. Includes visits by a staff member of a home health care agency (including an individual under contract or arrangement with the agency) during which any of the following services are provided:
  - Part-time or temporary nursing care performed by an R.N. or a licensed practical nurse (L.P.N.) or therapist
  - Occupational, Physical, Pulmonary, or speech therapy

  To be covered, home health care must be provided according to a home health care program set up in writing by a physician. The physician must state that the patient is, for all practical purposes, confined at home and the medical condition requires home health care. Visits must begin within 14 days after a hospital or skilled nursing facility stay unless the doctor certifies that the care is provided in lieu of such care.

To be covered, the home health care agency must:

- Be approved by the Plan. Contact the Plan for approval before arranging home health care services.
- Be approved by your area's health care planning agency (if applicable)
- Meet standards set by Medicare

- Hospice Care
  - Services furnished to a terminally ill patient after the date the patient enters the hospice care program
  - Bereavement counseling services incurred before the patient's death for the patient and within six months of the patient's death for covered participants of the immediate family when provided by a licensed social worker or licensed pastoral counselor

  To be covered, the hospice care program must:
  - Be approved by the Plan. Contact the Plan for approval before arranging hospice care services.
  - Be directed by a physician who certifies that the patient is terminally ill and not expected to live beyond six months
  - Meet standards set by the National Hospice Organization
  - If the program is required to be state licensed, certified, or registered, it also must meet that requirement
- Hospital Services – includes hospital charges for the following.
  - Room and board
    - For a semiprivate room, charges are covered at the most common rate.
    - For a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense.
    - For a private room in a private room only hospital, charges will be paid at 90% of the average private room rate.
  - Services required for medical or surgical care, whether as an outpatient or inpatient
  - Services of an R.N. or an L.P.N.
  - Emergency room services

  An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done only on an inpatient basis or a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.
- Laboratory studies
- Medical Supplies – includes supplies such as casts, splints, surgical dressings, catheters and colostomy bags.

- Mental Health – coverage for mental health services are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

  Includes inpatient, day treatment (partial hospitalization), and outpatient treatment, as well as intensive outpatient programs if approved by the Plan.
- Newborn Care – includes hospital nursery services and routine newborn care provided during the birth confinement or outpatient care following birth at home or in a birthing center. Also includes services and supplies for a covered newborn that is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the newborn is hospital confined.
- Pregnancy – includes prenatal visits and routine pre- and post-partum care, routine ultrasounds or an amniocentesis for genetic testing, hospital stays or birthing centers, and obstetrics provided by a physician or certified nurse-midwife (working under the direction of a physician) for pregnancy, childbirth, or related complications for you, your covered spouse, or dependent daughters.

  Pregnancy benefits are provided even if the pregnancy began before being covered under the Plan, as long as the mother is covered when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid. Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours. Precertification is required for any extended hospital stay.
- Prescriptions – includes medicines dispensed and administered during an inpatient stay.
  See Prescription Drug Benefit for outpatient prescription drug coverage information.
- Preventive Care
  If a recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of that service, the Plan will use reasonable medical management techniques to determine coverage limitations. Covered expenses include:
    - Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
    - Immunizations for routine use in children, adolescents and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. https://www.cdc.gov/vaccines/schedules/hcp/
    - Evidence-informed preventive care and screenings for infants, children and adolescents provided in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
    - Evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF for women. https://www.hrsa.gov/womens-guidelines/index.html

- Private Duty Nursing - covered inpatient 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.
- Prosthetics – includes charges for prosthetic appliances used to replace a missing natural body part which have been lost due to an accidental injury, sickness or surgery. To comply with the Women's Health and Cancer Rights Act, coverage also includes post-mastectomy breast prostheses. Also includes expenses related to the repair of a prosthetic or replacement of a prosthetic only when medically necessary due to a change in the patient's physical condition that makes the original device no longer functional.
- Reconstructive Surgery – includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; also includes surgery performed that is required to repair a congenital absence or agenesis (lack of formation or development) of a body part.

  Reconstructive surgery after a mastectomy - In a manner determined in consultation with the attending physician and the patient, includes reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage also includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.
- Reproduction / Sexual
    - Infertility Diagnosis – charges for the <u>diagnosis</u> of infertility only.
    - Sterilization – includes elective sterilization procedures for the employee and covered spouse only. Elective sterilization for any female participant of reproductive capacity is covered under Preventive Care.
      Excludes sterilization reversal.
- Second Surgical Opinions – covers a second surgical opinion you voluntarily obtain before recommended surgery. Second opinions provide you with more information so that you can make an informed decision about whether to have elective surgery or follow another course of treatment.
- Skilled Nursing Facility – includes room and board and nursing care provided under the treatment plan of a physician if the patient is confined as a bed patient in the facility, the confinement starts within 14 days of a hospital stay, and the attending physician certifies that the confinement is needed for further care of the condition for which the patient was hospitalized. Successive periods of confinement for the same cause will be a single period of confinement unless separated by 14 days. Services are only covered when the services are a substitute or alternative to hospitalization.
- Substance Abuse – coverage for substance abuse treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

  Includes inpatient, day treatment (partial hospitalization), and outpatient treatment, as well as intensive outpatient programs if approved by the Plan.

For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. It does not include dependence on ordinary drinks containing caffeine.

- Surgery – includes surgeries performed in a physician's office, outpatient facility or hospital.

  When an assistant surgeon is required to render technical assistance during an operation, the eligible covered expense will be limited to 20% of the Maximum Allowable Charge for the surgical procedure.

  If multiple surgeries are performed at the same time by one surgeon, the eligible covered expense is the fee for the major procedure plus 50% of the Maximum Allowable Charge for additional procedures performed through the same incision. Any procedure not integral to the primary procedure or unrelated to the diagnosis will not be covered.

  If multiple unrelated surgical procedures are performed by two or more surgeons, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a surgery normally performed by one surgeon, benefits for all surgeons will not exceed the Maximum Allowable Charge allowed for the procedure.
- Temporomandibular Joint Disorder (TMJ)
- Therapy – includes the following short-term rehabilitation therapy services due to an illness or injury or due to surgery performed because of an illness or injury. Excludes maintenance care.
  - Cardiac Rehabilitation – provided services are rendered:
    - Under the supervision of a physician
    - In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery
    - Initiated within 12 weeks after the other treatment for the medical condition ends
    - In a medical care facility as defined by the Plan.
  - Occupational therapy and therapy supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function; excludes recreational programs or supplies
  - Physical therapy by a licensed physical therapist or physician, but only to the extent that the therapy is for improvement of bodily function and provided in accordance with a physician's exact orders as to type, frequency and duration for conditions which are subject to significant improvement through short-term therapy
  - Pulmonary therapy for conditions that, in the judgment of a licensed provider and our medical director, are subject to significant improvement of your condition
  - Speech therapy by a licensed speech therapist, but only when ordered by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or sickness (other than a learning or mental disorder)

- Transplants – includes medically necessary and appropriate charges for organ and tissue transplant services. Transplants are limited to human organ transplants and bone marrow transplants (except Intraocular Lens Implants).

  When the organ or bone marrow recipient is a participant but the donor is not, approved transplant services will be considered for the donor. Benefits payable on behalf of the donor will be charged to the recipient's claim and subject to all applicable plan limits as shown in the Summary of Medical Benefits.

  A written request to the claims administrator must be made before the procedure is performed and be accompanied by documentation from the participant's physician, demonstrating the medical necessity of the proposed procedure. This request should also indicate at which hospital the transplant procedure will be performed and should be directed to:

  Mid-American Benefits, Inc.
  5310 North 99th Street, Suite 1
  Omaha, Nebraska 68134

- Wig after chemotherapy or radiation - includes initial purchase of a wig following chemotherapy or radiation.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the claims administrator at the number listed on the back of your medical ID card.

Medical Expenses Not Covered

To help you find specific exclusions more easily, we use headings (for example, Alternative Treatments), for services, treatments, items or supplies that fall into a similar category. A heading does not create, define, modify, limit or expand an exclusion.

The following expenses, among others, are not covered under the Plan:

- Alternative Treatments
    - Acupuncture or acupressure treatments unless administered by a physician holding the degree of a medical doctor or doctor of osteopathy
    - Charges for services or treatment including, but not limited to, aversion therapy, biofeedback, health club membership fees, music therapy, self-help programs, services rendered by a masseur / masseuse or any type of massage therapy, or other treatments such as ultrasound-guided extracorporeal shock wave therapy
- Behavioral Exclusions
    - Services, supplies, care, or treatment resulting from an intentionally self-inflicted injury or illness while sane or insane. This exclusion does not apply if the injury or illness resulted from being the victim of an act of domestic violence or from a documented medical condition (including both physical and mental health conditions).
    - Services, supplies, care, or treatment resulting from an injury or illness that results from, or is sustained while, engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm such as, but not limited to, skydiving, auto or powerboat racing, hang gliding, jet ski operating, rock climbing, or bungee or base jumping
    - Services, supplies, care or treatment resulting from an injury or illness that results from, or is sustained while, engaging in the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured participants other than the individual using controlled substances. This exclusion does not apply if the injury or illness resulted from being the victim of an act of domestic violence or from a documented medical condition (including both physical and mental health conditions).
    - Services, supplies, care or treatment resulting from an injury or illness that results from, or is sustained while, voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician. Expenses will be covered for injured participants other than the individual using controlled substances. This exclusion does not apply if the injury or illness resulted from being the victim of an act of domestic violence or from a documented medical condition (including both physical and mental health conditions).
    - Services, supplies, care, or treatment resulting from an injury or illness that results from, or is sustained while, engaging in an illegal act or occupation; by committing

or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. It is not necessary that criminal charges be filed, or if filed, that a conviction results. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the injury or illness resulted from being the victim of an act of domestic violence or from a documented medical condition (including both physical and mental health conditions).

- Comfort / Convenience Items and Services
    - Personal convenience items or equipment including, but not limited to, air conditioners, air purification units, blood pressure instruments, exercise equipment, elastic bandages or stockings, first aid supplies, heating units, humidifiers, meals, non-hospital adjustable beds, orthopedic mattresses, radios, scales, televisions and other non-prescription drugs or medicines
    - Services such as:
        - Custodial care
        - Maintenance care
        - Private duty nursing (out-patient)
        - Respite care
        - Rest cure
- Counseling
    - Services provided for marital, family, bereavement (unless covered under Hospice Care)
    - Dieticians and/or nutritionists services and nutrition programs
    - Educational or vocational services
- Dental / Oral
    - Charges for dental care provided by an active dental plan
    - Orthodontia or related services
- Durable Medical Equipment
    - Any device unless there is sufficient change in the patient's condition to make the original device no longer functional or the age of the device makes it no longer functional. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.
- Hearing
    - Hearing exams or hearing aids including related services or supplies or fitting exams, except as may be covered under the well adult or well child sections of this Plan
- Hospice
    - Charges incurred after the patient is discharged from the hospice care program
    - Skilled nursing services if they are provided in a place designed mainly for custodial care

- Hospital Services
    - Any hospital stay that is not for the diagnosis or treatment of a sickness or injury
    - Deafness or blindness
    - Mental illness, except for short-term care when recovery or improvement is deemed likely
    - Non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission
    - Senility, mental deficiency, or retardation
- 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
- Physical Appearance
    - Care and treatment of hair loss (excludes wig following chemotherapy or radiation)
    - Services for cosmetic reasons, except for covered reconstructive surgery
    - Services, supplies, or treatment primarily for weight control or treatment of obesity or morbid obesity, including, but not limited to, gastrointestinal surgery, hormones, medications, exercise programs or use of exercise equipment, special diets or supplements, appetite suppressants, weight loss programs, and hospital confinements for weight reduction programs.
- Podiatry / Foot Care
    - Diagnosis, routine care and treatment for the feet including orthotics, orthopedic shoes, orthopedic prescription devices, arch supports, treatment of weak, strained, flat, unstable or unbalanced feet, subluxations of the foot, metatarsalgia, non-surgical care of bunions (except open cutting operations) and treatment of corns, calluses, or toenails (unless necessary for treatment of metabolic or peripheral-vascular disease); also excludes any charges for the exam or fittings
- Reproduction / Sexual
    - Abortion (surgical, non-surgical, or drug-induced) unless:
        - The life of the mother is endangered by the continued pregnancy
        - A live birth is not possible
        - The pregnancy was the result of rape or incest

      Expenses incurred to treat complications arising after the performance of an abortion are covered.
    - Diagnosis, care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity not related to organic disease
    - Fertility and infertility treatments, such as in-vitro fertilization, fertility assistance, and other artificial insemination procedures; adoption or surrogate expenses
    - Services, supplies, or treatment for transsexualism, gender dysphoria, or sexual assignment or change, including medications, implants, hormone therapy, surgery, or medical or psychiatric treatment
    - Sterilization reversals

- Residence and Vehicle Modifications
    - Modifications such as, but not limited to, ramps, grab bars or railings, whether or not recommended by a physician
- Residential treatment – is not covered for any reason
- Services Provided by another Plan
    - Services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan
    - Services for any condition, illness, or injury, or complication thereof arising out of or in the course of employment, when the participant is furnished care or services covered hereunder, or could or might have been furnished such care and services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law, or any other law or regulation of the United States, or of a state, territory or subdivision thereof, or under any policy of Worker's Compensation or occupational disease insurance, or according to any recognized legal remedy available to the participant
- Sleep disorders unless deemed medically necessary
- Travel-Related Expenses
    - Travel and accommodation expenses unless provided under the Plan for a particular service
    - Expenses for care or treatment outside of the United States if travel was for the sole purpose of obtaining medical services
- Vision
    - Routine eye exams, eyeglasses, contact lenses or related services. This exclusion does not apply to the initial eyeglasses or lenses after a cataract operation or lenses necessary to treat keratoconus, aphakic patients, or soft lenses or sclera shells for use as corneal bandages.
    - Radial keratotomy or any other surgery to correct nearsightedness or refractive errors
- All Other
    - Autopsies
    - Charges for failure to keep a scheduled visit, telephone or internet consultations, completion of claim forms or forms necessary for a return to work or school, or charges for records or reports
    - Excess – charges that are not payable under the Plan due to application of any stated Plan maximum or limit, or because the charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be medically necessary, or are otherwise not covered by this Plan, based upon the Plan Administrator's determination as set forth by and within the terms of this document.
    - Expenses resulting from complications of a treatment or service not covered by the Plan. This exclusion does not apply to abortion. This includes expenses resulting from complications that arise from any previous treatment or service if it is a non-covered service under this Plan.

- Experimental or investigational services or supplies
- Military related illness or injury to a participant on active military duty, unless payment is legally required
- 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
- Services rendered by an unlicensed provider
- Services or supplies for sickness, defect, disease, or injury due to war or a warlike action, whether declared or undeclared. This exclusion does not apply to participants who are civilians injured or otherwise affected by war or any act of war, whether declared or undeclared.
- Services, supplies or treatment received before the patient is covered by the Plan or after coverage ends under the Plan
- Services or supplies for which the patient does not have to pay or for which no charges would be made if this coverage did not exist
- Services, supplies, or treatment not recommended and approved by a physician or when the participant is not under the regular care of a physician that is appropriate care for the injury or sickness
- Services, supplies, or treatment performed or ordered by an individual who ordinarily resides in the participant's home or who is related to the participant, whether the relationship is by blood or exists in law
- Services, supplies, treatment or therapy that is court ordered or that is ordered as a condition of parole, probation or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.
- Services, supplies, treatment or therapy while a participant is incarcerated or in the custody of law enforcement

Precertification

Participants must obtain precertification for all inpatient hospitalizations, outpatient surgeries, and certain other treatments such as CT, MRI, or PET scans. This program is designed to determine what charges may be eligible for payment by the Plan. Please remember that precertification does not guarantee payment. All other group plan provisions apply. For example: copayments, deductibles, coinsurance, eligibility and exclusions.

It is not designed to be the practice of medicine or to be a substitute for the medical judgment of your attending physician or health care provider. In some cases, the provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit and are not penalized, you should verify that the request was submitted to the Plan.

How to Precertify

To receive the maximum benefit and avoid any penalty for failure to precertify, you (or a family member or attending physician) must call to precertify an admission or treatment:

- At least 7 to 10 days in advance of any scheduled or non-emergency hospital admission
- At least 7 to 10 days in advance of any scheduled outpatient surgeries or certain other treatments, such as MRI, CT, or PET scans
- Within 48 hours (72 hours if confinement starts on a Friday or Saturday) of an emergency or unscheduled hospital admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.
  NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.

Call Hines at 1-800-944-9401 prior to receiving or scheduling services
FAILURE TO PRE-CERTIFY MAY RESULT IN A REDUCTION OF BENEFITS
AUTHORIZATION IS NOT A GUARANTEE OF BENEFITS
ALL VERIFICATIONS & BENEFITS SUBJECT TO PLAN PROVISIONS & LIMITATIONS

For hospital admissions, the precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your request for extension will be denied and you may file an appeal of the denial through the Plan's appeal process.

Diagnostic Imaging – 800-903-3646

All Out-of-Network non-emergency MRI's (Magnetic Resonance Imaging) and CAT scans (Computed Axial Tomography) for any participant needs to be set up through and performed by a Care IQ Facility. The toll free phone number for establishing an appointment at a Care IQ Facility is located on your identification card. This number must be called to arrange services at the approved facility. This benefit is subject to deductible and coinsurance.

Any Out-of-Network non-emergency MRI or CAT scan not set up through or performed at a Care IQ Facility will have an additional $200.00 copay to be paid by the participant.

Pregnancy and Childbirth Precertification

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. If/when the pregnancy confinement for the mother or newborn is expected to exceed these limits,

precertification for such extended confinement is required. The Plan must also be notified before any hospital admission for complications that occur during the pregnancy.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by $500.00. In addition, if it is determined subsequently that all, or part of, the services provided were not medically necessary, all or part of the expenses will be denied. The Plan does not pay benefits beyond the number of days the Plan considers the admission to be medically necessary.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The case manager consults with the patient, the family, and the attending physician to develop a plan of care for approval by the physician and the patient. This is a voluntary service provided by the Plan. There are no reductions or penalties if you choose not to participate.

The Plan Administrator may arrange for review and/or case management services from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS)
- Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
- Burns
- Cancer
- Certain psychiatric conditions
- Coma
- Inpatient confinement expected to exceed 14 days
- Multiple sclerosis
- Multiple traumas from a vehicular accident
- Neonatal birth
- Organ transplant
- Progressive neurological debilitative disease
- Quadriplegic/paraplegic conditions
- Stroke

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

Prescription Drug Benefits

If you elect coverage under the Plan, you are automatically enrolled in the Prescription Drug program. This program helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- Prescribed by a licensed physician or dentist and dispensed by a registered pharmacist
- Approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network administered by Magellan Rx Management, which includes most major pharmacies. Your prescriptions can be purchased at a network retail pharmacy using your identification card or through the mail-service program for maintenance medications and any prescription drugs not needed immediately. You can receive up to a 30-day supply of a prescription at any network retail pharmacy using your identification card or up to a 90-day supply for most medications through the mail-service program.

To fill a prescription through the mail-service program, you must complete an order form. Payment can be made using a credit card, check, or money order. With your first order, you also must include the original prescription order written by your physician and a completed patient profile form. Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a refill notice that may be used to request a prescription refill; you do not need a new prescription from your physician if the prescription is still valid. Refills can also be conveniently refilled by phone or by using Magellan Rx's Web site.

A list of participating pharmacies can be found on Magellan Rx's Web site: http://www.magellanrx.com or by calling 800-424-5828.

If you obtain a prescription at a non-participating pharmacy, charges are not covered.

Copayment

There are three tiers in the prescription drug program. Each has a different copayment that applies depending on the type of drug.

Generic Drugs

- 20% copayment per prescription at a network retail pharmacy for up to a 30 day supply ($7.50 minimum / $10.00 maximum. If prescription is less than $7.50, the copayment is the cost of the prescription.)
- 20% copayment per prescription through the mail service program for up to a 90 day supply ($15.00 minimum / $20.00 maximum. If prescription is less than $15.00, the copayment is the cost of the prescription)

Using generic drugs when available, instead of costlier brand name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand name drug in safety and effectiveness when taken as prescribed. If a generic drug is available, it will automatically be dispensed.

Formulary Brand Name Drugs

- 20% copayment per prescription at a network retail pharmacy for up to a 30 day supply ($15.00 minimum / $25.00 maximum. If prescription is less than $15.00, the copayment is the cost of the prescription.)
- 20% copayment per prescription through the mail service program for up to a 90 day supply ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copayment is the cost of the prescription.)

This category includes brand name drugs for which there are no or limited generic drug alternatives. Most brand name drugs used to treat asthma or diabetes are included in this category. If a generic drug is available, it will automatically be dispensed. If the physician or participant requests a Formulary Brand Name Drug and a generic is available, the participant will pay 100% of the cost.

Non-Formulary Brand Name Drugs

- 20% copayment per prescription at a network retail pharmacy for up to a 30 day supply ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copayment is the cost of the prescription.)
- 20% copayment per prescription at a network retail pharmacy for up to a 90 day supply ($60.00 minimum / $100.00 maximum. If prescription is less than $60.00, the copayment is the cost of the prescription.)

This category includes brand name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. If a generic drug is available, it will automatically be dispensed. If the physician or participant requests a Non-Formulary Brand Name Drug and a generic is available, the participant will pay 100% of the cost.

Over The Counter Medications

The following Over-The-Counter medications will be reimbursed after documentation has been submitted to the claims administrator. (i.e. receipt and product label.) These medications will be paid at 100%. Only the medications listed will be eligible for this benefit. Only one of each class of medications will be reimbursed in a 30-day period for each Participant. Adult and children's medications will be eligible for reimbursement.

Antihistamines/Cough/Cold/Allergy
Hy-Vee Allergy Relief Series
Hy-Vee OHM
Hy-Vee All Day Allergy
Hy-Vee Tussin
Walgreens Wal-itin
Walgreens Wal-itin D
Walgreens Wal-Zyr
Walgreens Wal-tussin
Walmart Equate Allergy Relief
Walmart Allergy Relief 24 hour
Walmart Equate Allergy
Walmart Equate Tussin CF or DM

Heartburn/Acid Reflux
Pepcid AC
Zantac 74 150
Prilosec OTC
Tagamet HB
Axid AR
Wal-Zan

Specialty Medications

All Specialty Medications are to be purchased through Magellan Rx by calling 800-424-5828, regardless of where drugs are to be administered, except as required in an emergency.

The eligible Specialty Medication will be subject to deductible and coinsurance.
Specialty Medication prescriptions are limited to a 90-day supply.

Prior Authorization and Limits

Certain prescriptions may require prior authorization in order to be covered. Other drugs may be limited by drug-specific quantities or may be approved only when other drugs have not been effective in treating a specific condition. If your pharmacist advises you that a prescription is affected by these limits, additional documentation will be required from your physician before your prescription can be approved under the Plan. Contact the claims administrator shown on your ID card for questions regarding this provision.

Eligible Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Acne products (Retin A, Azelex)
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin)
- AZT, Retrovir, and other drugs used for the purpose of treating AIDS, unless experimental or investigational
- Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity
- Contraceptives – charges for oral contraceptives (e.g. Ortho-Novum, Lo/Ovral, Seasonale), contraceptive patches (e.g. OrthoEvra), contraceptive vaginal rings (e.g. Nuva-Ring), contraceptive devices (e.g. diaphragms, IUD's), contraceptive injectables (e.g. Depo-Provera), and contraceptive implants (e.g. Norplant).
    - Prescription oral contraceptives and patches are covered under the prescription drug portion of the Plan.
    - All other types of covered prescription contraceptives are considered under the medical plan.
- Diabetic supplies such as Chemstrips, Insulin, disposable insulin pens (non-disposable insulin pens are considered medical supplies and are covered under medical benefits), insulin cartridges, and pen needles
- Drugs prescribed by a physician that require a prescription either by Federal or state law
- Vitamins
    - Prescription prenatal vitamins
    - Prescription vitamin supplements containing fluoride

Prescription Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

- Charges for the administration or injection of drugs
- Cosmetic related drugs such as anabolic steroids or Retin A
- 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.
- Drugs not approved by the Food and Drug Administration (FDA)
- Drugs that are consumed or administered at the place where it is dispensed. This includes any drug that is to be taken by the participant, 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.
- Drugs or supplies covered under workers' compensation or occupational disease law or any similar law
- Drugs and medicines that may not be prescribed within the scope of the physician's license
- Growth hormones unless there is a laboratory-confirmed diagnosis of growth hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease
- Hair loss or hair restoration drugs (e.g., Minoxidil)
- Impotence or sexual dysfunction medications
- Infertility / fertility drugs
- Investigative drugs or drugs classified by the FDA as experimental
- Injectable drugs (other than self-injectables) and supplies (i.e., hypodermic syringes and/or needles), other than for insulin
- Prescriptions dispensed in excess of the number specified by the physician or dispensed more than one year after the physician's original order
- Vitamin supplements, dietary supplements or food supplements, even if prescribed by a physician. This exclusion does not apply to prenatal vitamins or vitamin supplements containing fluoride.
- Weight loss drugs or appetite suppressants

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the claims administrator at the number listed on the back of your prescription drug ID card.

Dental Benefits

Network Provisions

This Plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the Plan encourages, but does not require, participants to seek dental care from dentists and dental care facilities that belong to Connection Dental PPOUSA, a dental preferred provider organization (PPO). The Connection Dental Network offers excellent dental cost containment provisions and nationally competitive discounts. You may find participating providers at www.PPOUSA.com.

By utilizing the Connection Dental PPOUSA contracted providers, you may receive lower cost dental care which creates a positive financial impact for you and the Plan.

Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is $25.00 per individual and $75.00 per family. The annual deductible does not apply to Type A (preventative) services. The dental deductible is separate from any medical or prescription drug deductible you may incur.

Your deductible does not include:

- Any expenses not covered under the Plan
- Amounts in excess of Maximum Allowable Charge

Coinsurance

The Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance and is based on the type of service you receive.

Covered Services

The Plan provides benefits for preventative, basic, and major services. In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform to generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Maximum Allowable Charge. Maximum Allowable Charge expenses are based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area. The Plan pays benefits up to the Maximum Allowable Charge. If your provider charges more than the Maximum Allowable Charge amount, you are responsible for paying any excess charges above this limit.

A service or supply is not covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the claims administrator shown on your ID card.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be $500.00 or more, you may need to obtain a predetermination of benefits using a dental claim form. The completed form should be sent to the claims administrator who will notify your dentist of the benefits payable under the Plan. If a predetermination of benefits is required and not submitted, the Plan will make a determination of benefits payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice.

Predetermination is not a guarantee of payment. It tells the participant and his/her dentist, in advance, what the Plan would pay for the covered dental services named in the treatment plan.
Payment is conditioned on:

- The work being done as proposed and while the participant is covered under this Plan; and
- The deductible and payment limit provisions; and
- All of the other terms of this Plan

Emergency treatment, oral examinations, dental x-rays and teeth cleaning are part of a course of treatment but may be done before the Predetermination of Benefits is made.

Dental Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

- Anesthesiologists services
- Barrier technique or sterilization of dental equipment and supplies
- Charges for failure to keep a scheduled visit, telephone or internet consultations, completion of claim forms or forms necessary for a return to work or school, or charges for records or reports
- Correction of congenital conditions
- Cosmetic services and supplies, personalization or characterization of any prosthetic device or bleaching of teeth
- Crowns, fillings, appliances or procedures that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth or restoring the bite (occlusion)
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist
- Duplicates or replacement of lost, missing, or stolen prosthetic devices or other dental appliances
- Education and training in personal oral hygiene, dental plaque control, or dietary and nutritional counseling
- Excess – charges that are not payable under the Plan due to application of any stated Plan maximum or limit, or because the charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be medically necessary, or are otherwise not covered by this Plan, based

upon the Plan Administrator's determination as set forth by and within the terms of this document.

- Expenses for dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth)
- Expenses which are eligible under a medical plan or policy
- Experimental or investigational services or supplies
- Facings on pontics or crowns posterior to the second bicuspid or precision attachments
- Implants, including any appliances and/or crowns for implants, and the surgical insertion or removal of implants
- Occlusal analysis, occlusal adjustments, occlusal guards, mouth guards or any similar take home item
- Orthodontia
- Services not shown in the Summary of Dental Benefits
- Services performed by an individual who ordinarily resides in the participant's home or who is related to the participant, whether the relationship is by blood or exists in law
- Services or supplies which are covered by any workers' compensation or occupational disease laws
- Services or supplies for which the patient does not have to pay or for which no charges would be made if this coverage did not exist
- Services or supplies that do not meet the standards of dental practices and accepted by the American Dental Association
- Services or supplies furnished in a United States Government hospital
- Services or supplies due to war or a warlike action, whether declared or undeclared. This exclusion does not apply to participants who are civilians affected by war or any act of war, whether declared or undeclared.
- Services, supplies or treatment received before the patient is covered under the Plan or after coverage ends under the Plan
- Veneers (bonding of coverings to the teeth)

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the claims administrator at the number listed on the back of your ID card.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right individual for information or help. Although you may not use this information often, it can be helpful if you want to know:

- How to contact the Plan Administrator;
- How to contact the claims administrators
- What to do if a benefit claim is denied
- Your rights under Federal laws such as COBRA

Plan Sponsor and Administrator

Transit Authority of the City of Omaha, dba, METRO is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number.

Plan Administrator:
Transit Authority of the City of Omaha, dba, METRO
2222 Cuming Street
Omaha, NE 68102
(402) 341-7560

The Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law
- To prepare and furnish appropriate information to eligible employees and participants
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan
- To receive such information or representations from the employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards
- To delegate to any individual or entity such powers, duties, and responsibilities as it deems appropriate for the administration of the Plan
- To maintain and preserve appropriate Plan records
- To accept all other responsibilities and duties of the administrator of the Plan

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is January 1 through December 31.

Type of Plan

This Plan is a called a "welfare plan". They help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:
EIN: 47-0542132
Plan Number: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows:

Plan Funding	The employer and employees both contribute to the Plan. Assets of the Plan are used for the exclusive purpose of providing benefits to participants and their beneficiaries. Any contributions will remain part of the general assets of the employer and benefits will be paid solely from those general assets.
Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.

Claims Administrator

The Plan Administrator has contracted with the following company to administer benefits and pay claims. You may contact the claims administrator directly, using the information listed below.
Your claims administrator is also listed on your ID card.

Mid-American Benefits, Inc.
5310 North 99 Street, #1
Omaha, NE 68134
(402) 571-6224 or 1-800-364-9505
http://www.mid-americanbenefits.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Plan Administrator:
Transit Authority of the City of Omaha, dba, METRO
2222 Cuming Street
Omaha, NE 68102
(402) 341-7560

No Obligation to Continue Employment

The Plan does not create an obligation for the employer to continue your employment or interfere with the employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the provider, unless otherwise assigned.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Notice of Payment Due

If the Plan Administrator cannot locate any person to whom a payment is due, after six (6) months from the date such payment is due, a notice of payment due will be mailed to the last known address of that person. If, within three (3) months after that mailing, such person has not made written claim, the Plan Administrator may direct that such payment and all remaining payments otherwise due to such person be canceled. The Plan shall have no further liability upon such cancellation.

Expenses

All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the employer elects to pay such expenses.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any participant who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the employer, up to and including, termination of employment.

Indemnity

To the full extent permitted by law, the employer will indemnify the Plan Administrator and each employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, and Title I of GINA.

This Plan is fully exempt from ERISA. The Plan shall be governed and construed in accordance with the laws of the State of Nebraska to the extent not preempted by Federal law.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated participants.

Plan Rights for Audits

The Plan Administrator may use its discretionary authority to perform itself and/or utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are in excess of the Maximum Allowable Charge, not medically necessary or not an eligible expense, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge, not medically necessary and/or not an eligible expense or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge amount and cap payable amounts at the maximum eligible expense in accord with the terms of this Plan Document.

Future of the Plan

The employer expects that the Plan will continue indefinitely. However, the employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received.

How to Submit a Claim

When a participant has a claim to submit for payment:

1. Obtain a claim form from the Personnel Office or Plan Administrator for each covered family member who has expenses.
2. Complete the "Employee" portion of the form. Be sure to answer all questions.
3. Have your provider complete the "Provider" section of the form.
4. For reimbursement, attach bills for services rendered. All bills must show:
   Name of Plan
   Employee's Name
   Patient's Name
   Name, Address and Telephone Number of the provider
   Diagnosis
   Type of Service Rendered, including Diagnostic / Procedure Code(s)
   Date of Service
   All Charges for Services Rendered
   Note: If you have already paid all or a portion of the expenses to the provider, indicate any amount paid on the claim form and submit proof of payment with your claim form.
5. Send the completed claim form and any attachments to the appropriate claims administrator shown on your ID card.

Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that a participant is entitled to them. Benefits are payable based on the Plan's provisions at the time the charges were incurred. For In-Network benefits, covered services are generally paid to the provider. If you use Out-of-Network providers, you may need to pay them when services are received and request that payment be made to you. If the Plan reimburses the provider directly and you have already paid your provider, you will need to request a refund from your provider.

Payment Processing

Benefits are payable when the Plan Administrator receives written proof of loss. You should file a claim as soon as possible. To be eligible for reimbursement under the Plan, a claim must be submitted within six months of the date the expense was incurred. Claims filed after that time may be reduced or denied. If it is not reasonably possible for you to file a claim within this time frame, the Plan Administrator may elect to approve payment of the claim after reviewing any extenuating circumstances if the claim is filed as soon as reasonably possible.

For medical expenses, the claims administrator will send an Explanation of Benefits showing what expenses the Plan covered. If an expense is not eligible for payment, or if a provider charges in excess of the amount the Plan allows, you may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fails to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The following chart shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your claims administrator at the number shown on your ID card.

Time Frames for Processing a Claim				
Claim Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
Claims administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim	For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*	Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of claims administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the claims administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. The time frames for appealing a claim are shown in the following chart.

If you or your representative submits an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims				
Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the claims administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received
External Review Process	Refer to **External Review Process** below			

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. 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 Plan Administrator will determine whether the claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

- The claimant is or was covered under the Plan at the time the claim was made or incurred
- The denial relates to the claimant's failure to meet the Plan's eligibility requirements
- The claimant has exhausted the Plan's internal Claims and Appeal Procedures
- 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 Plan 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 Plan 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. 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:

- The claimant's medical records
- The attending health care professional's recommendation
- Reports from appropriate health care professionals and other documents submitted by the
- Plan or issuer, claimant, or the claimant's treating provider
- The terms of the Plan
- Appropriate practice guidelines
- Any applicable clinical review criteria developed and used by the Plan
- The opinion of the IRO's clinical reviewer

The IRO 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:

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

- 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
- 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 notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualities 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.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in State court, as you will not have exhausted your administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which participant's might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a participant is covered by another plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your benefits are coordinated with benefits from:

- Other employers' plans
- Individual plans
- Certain government plans
- Motor vehicle plans when required by law

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- The primary plan is determined and pays the full amount it normally would pay first. It pays all benefits that it would pay if there were no other plans
- The secondary plan pays next. It pays a reduced amount which when added to the benefits paid by the primary plan will pay no more than 100% of total expenses. However, no secondary plan ever pays more than it would pay without the coordination of benefits provision.
- If another plan is primary and this Plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount. If any balance remains, it is your responsibility.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.

- If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
- If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
- If the remarried parent with custody has no coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will continue and this Plan will be your primary coverage, with Medicare as secondary coverage. If you choose to have Medicare as your primary coverage, your coverage under this Plan will terminate.

The Plan also coordinates with Medicare as follows:

- End-stage renal disease - If a participant is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan - If a participant is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. This also applies to the benefit that an auto insurance plan would pay if auto insurance is legally required but not in force. Coverage under the Plan will be secondary regardless of the participant's coverage election on an auto insurance policy.

If a participant incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- Any deductible under the automobile coverage
- Any copayment under the automobile coverage
- Any expense properly denied by the automobile coverage that is a covered expense;
- Any expense that the Plan is required to pay by law

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Third Party Recovery, Subrogation and Reimbursement

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the participant shall be a trustee over those Plan assets.

3. In the event a participant(s) settles, recovers, or is reimbursed by any coverage, the participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the participant(s). If the participant(s) fails to reimburse the Plan out of any judgment or settlement received, the participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the participant(s) fails to so pursue said rights and/or action.

2. If a participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any participant(s) may have against any coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the participant(s) commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

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

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically

designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

<u>Participant is a Trustee Over Plan Assets</u>

1. Any participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the participant understands that he/she is required to:
   a. Notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
   b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
   c. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
   d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the participant disputes this obligation to the Plan under this section, the participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the participant's/participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the participant may have against any responsible party or coverage.
    h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    i. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and participant over settlement funds is resolved.

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

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

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

Your Rights under the Plan

As a participant in the Plan, you are entitled to certain rights and protections.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other individual, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) and do not receive it within 30 days, you may file suit in a State court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in State court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a State court. The court

will decide who should pay court costs and legal fees. If you are successful, the court may order the individual you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (listed in your telephone directory).

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- Enrollment of eligible individuals
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

If a participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific claims administrator involved with the PHI in question. The claims administrator will advise the participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the employer with respect to such information. The employer will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan Sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

Continuing Coverage through COBRA

In special situations, a participant may continue coverage at the participant's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If a participant chooses COBRA coverage, the employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, participants may continue the same coverage under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next Annual Open Enrollment period to enroll your child.

COBRA Qualifying Events and Length of Coverage

Each individual enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such individual losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- Employment ends for any reason other than gross misconduct; or
- Hours of employment are reduced

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled individual may receive an extra 11 months of coverage in addition to the 18- month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- He or she becomes disabled before or within the first 60 days of the initial 18-month coverage period
- He or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination
- He or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- Death
- Dependent child's loss of eligible dependent status under this Plan
- Divorce or legal separation
- Eligibility for Medicare coverage

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally not considered part of your COBRA continuation coverage period. (See "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins:

- At the end of the leave if you do not return after the leave; or
- On the date of termination if you decide to terminate your employment during the leave

When COBRA Coverage Ends

COBRA coverage for a participant will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare. However, in the case of a qualifying event that results from a termination of employment or reduction of hours for an employee who becomes or is eligible for Medicare, the COBRA coverage for a spouse may continue for a period of up to 36 months from the date of the qualifying event or, if earlier, the date the spouse becomes entitled to Medicare or other coverage.
- The employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident - An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work - A participant is considered actively at work if he or she is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or was present at work on the last scheduled working day before:

- A scheduled vacation;
- An absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
- A scheduled day off within the participant's working schedule; or
- An absence excused by the employer

Advanced Diagnostics Imaging – Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics, such as computed tomography (CT) scans, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), MRI of the breast, magnetic resonance spectroscopy (MRS), functional brain MRI (MRI), positron emission tomography (PET) scans, single photon emission computed tomography (SPECT) scans and other nuclear medicines.

Ambulatory Surgical Facility – A certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be licensed as a health clinic as defined by state statutes, but shall not include the offices of private physicians or dentists whether for individual or group practice.

Approved Provider – A licensed practitioner of the healing arts who provides covered services within the scope of his or her license or a licensed or certified facility or other health care provider.

Assignment of Benefits - An arrangement whereby the participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, copayments and the coinsurance percentage that is the responsibility of the participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the participant as the sole beneficiary.

A provider which accepts an assignment of benefits in accordance with this Plan does so as consideration in full for services rendered, and is bound by the rules and provisions set forth within the terms of this document.

Auxiliary Provider – A certified social worker, psychiatric registered nurse, provisional licensed mental health practitioner, provisional PhD, provisional certified master social worker, provisional certified alcohol and drug counselor or other approved provider who is performing services within his or her scope of practice and who is supervised, and billed for, by a qualified physician or licensed clinical psychologist, or as otherwise permitted by state law. Certified master social workers or certified professional counselors performing mental health services who are not licensed mental health practitioners are included in this definition.

Birthing Center – A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

Certification (Certify and Certified) – A determination by our designee, that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Certified Nurse / Midwife - A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a physician, bill for services under the physician's taxpayer ID, and provide services in line with nurse-midwife certification.

Claim – A request for benefits under this Plan.

Clinical Trials – Phase I, II, III, or IV trials meet the definition of an approved clinical trial if they are:

1. Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and
2. One of the following occurs:
   A. Federally funded, or
   B. Either
      - ✓ Conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration, or
      - ✓ A drug trial that is exempt from the IND application requirements

COBRA - The Consolidated Omnibus Budget Reconciliation Act, as amended. This Federal law allows a continuation of coverage in certain circumstances.

Cognitive Training – A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

Coinsurance – The percentage amount the participant must pay for covered services which is based on the lesser of the contracted amount or the billed charge.

Concurrent Care Claim - A claim for a benefit that involves an ongoing course of treatment.

Congenital Abnormality – A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a Congenital Abnormality.

Consultations – Physician's services for a patient in need of specialized care requested by the attending physician who does not have that expertise or knowledge.

Convenient Care / Retail Clinic – A medical clinic located in a retail location such as a grocery or drug store, where a provider offers treatment of minor medical conditions, immunizations and physicals without an appointment.

Copayment (Copay) – A fixed dollar amount of the contracted amount, payable by the participant for a covered service.

Cosmetic – Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Expense - A covered service provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge, is or is for a Reasonable and Appropriate covered service for an eligible Medically Necessary covered service, meant to improve a condition or health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the covered service is the least costly option that is no less effective than any other option. All treatment is subject to benefit payment maximums shown in the Summary of Medical/Prescription/Dental Benefits and as set forth elsewhere in this document.

Covered Service – Any single service or combination of services, and/or fees for which benefits are payable, while the Plan is in effect.

Custodial Care – The level of care that consists primarily of assisting with the activities of daily living such as, but not limited to, bathing, dressing, walking, preparing meals, continence or transferring, whether in a residential care facility, skilled nursing facility, or at home. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care includes, but is not limited to:

1. Care given to a patient who:
    A. Is mentally or physically disabled; and
    B. Needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
    C. May be ventilator dependent or require routine catheter maintenance.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more

independent existence;

3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively, such as recording pulse, temperature, and respiration; supervising medications that can usually be self-administered; or administration and monitoring of feeding systems.

Deductible – An amount which the participant must pay each calendar year for covered services before benefits are payable by the contract.

Diagnostic Service - A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Durable Medical Equipment – Equipment and supplies which treat an illness or injury, to improve the functioning of a particular body part, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, able to withstand repeated use, it is not useful in the absence of an illness or injury, or it is appropriate for use in the home. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

Eligibility Date – The date an employee's coverage becomes effective on the group contract after meeting the eligibility requirements, including any applicable probationary period.

Eligibility Waiting Period – Applicable to new participants only, the period between the first day of employment and the first date of coverage under the contract. This period may include a probationary period.

Emergency Care – Any covered services provided in a hospital emergency room setting for an Emergency Medical Condition.

Emergency Medical Condition – A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such individuals or others in serious jeopardy, 2) serious impairment to such individual's bodily functions, 3) serious impairment of any bodily organ or part of such individual, or 4) serious disfigurement of such individual.

Employee – An individual who is an employee and is regularly scheduled to work for the employer in an employer-employee relationship. An employee must normally be scheduled to work at least 30 hours per week in order to be eligible for coverage.

Experimental or Investigational Services - Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the United States Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- Not demonstrated through authoritative medical or scientific literature published in the United States to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed

Family and Medical Leave Act - The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- The birth or adoption of a child or placement of a foster child in a participant's home
- The care of a child, spouse, domestic partner or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition
- A participant's own serious health condition
- Any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if:

- You have worked for your employer for at least one year;
- You have worked at least 1,250 hours during the previous 12 months;
- Your employer has at least 50 employees within 75 miles of your worksite; and
- You continue to pay any required premium during your leave as determined by the employer

You should contact the employer with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Generic Drug Alternative - A generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent – A generic drug that has the exact same active ingredients as the brand name drug. When a drug patent expires, other companies may produce a generic version of the brand name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information - Genetic information includes information about genes, gene products, and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status or information derived from laboratory tests that identify mutations in specific genes or chromosomes, medical examinations, family histories, or direct analysis of genes or chromosomes.

Genetic Testing – in accordance with the Genetic Information Nondiscrimination Act of 2008, the Plan will not discriminate against any participant on the basis of genetic information. This includes any information obtained for an individual from genetic tests, genetic tests of family members, and the manifestation of a disease or disorder in family members.

GINA - The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA - Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH - The Health Information Technology for Economic and Clinical Health Act, as amended.

Hospice - A program of care provided for individuals diagnosed as terminally ill and their families.

Hospital - A hospital is an institution or facility duly licensed by the state in which it is located, which provides medical, surgical, diagnostic and treatment services with 24 hour per day nursing services, to two or more nonrelated individuals with an illness, injury, or pregnancy, under the supervision of a staff of physicians licensed to practice medicine and surgery.

Illness - A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

Improper Claim - A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim - A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Independent Laboratory – A freestanding facility offering radiology and pathology services which is not part of a hospital and is licensed by the proper authority in the state in which it is located.

Injury – Physical harm or damage inflicted to the body from an external force.

In-Network Provider – A health care provider (hospital, physician or other health care provider) of health care services who has contracted with us to provide services as a part of a preferred provider network.

Inpatient – A patient admitted for 24 consecutive hours or more to a hospital or other institutional facility for bed occupancy to receive services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting. How the facility classifies the stay is irrelevant, any confinement satisfying this definition will be subject to all health plan provisions relating to inpatient admissions, including any applicable preadmission review requirements.

Late Entrant – An individual who does not enroll for coverage during the first period in which he or she is eligible or during a Special Enrollment Period.

Licensure (Licensed) – Permission to engage in a health profession that would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Long Term Acute Care (LTAC) – Specialized acute hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour / seven-day-a-week basis.

Managed Care - A type of health care delivery system that combines physician choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Maximum Allowable Charge - The benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed:

- The Reasonable and Appropriate amount;
- The maximum charge otherwise allowed under all terms of the Plan;
- Plan negotiated rates with a provider, whether directly or through a network; and/or
- The actual billed charges for the covered expense.

The Plan will reimburse the actual charge if it is less than the Reasonable and Appropriate amount(s). The Plan has the discretionary authority to decide if a charge is Reasonable and Appropriate and otherwise covered under the Plan.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medicaid – Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

Medical Condition - A condition for which the individual has sought and received medical treatment.

Medically Necessary Or Medical Necessity – Health care services ordered by a treating physician exercising prudent clinical judgment, provided to a participant for the purposes of prevention, evaluation, diagnosis or treatment of that participant's illness, injury or pregnancy, that are:

1. Consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the participant's illness, injury or pregnancy. The most appropriate setting and the most appropriate level of service is that setting and that level of service, considering the potential benefits and harms to the patient. When this test is applied to the care of an inpatient, the participant's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. Not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's illness, injury or pregnancy, without adversely affecting the participant's medical condition; and
4. Not provided primarily for the convenience of the following:
    a. The participant;
    b. The physician;
    c. The participant's family;
    d. Any other individual or health care provider; and
5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

Medicare – The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Services Provider – A qualified physician, licensed psychologist, licensed special psychologist or licensed mental health practitioner. A licensed mental health practitioner may also be a licensed professional counselor or a licensed clinical social worker who is duly certified / licensed for such practice by state law. It also includes auxiliary providers supervised, and billed for, by a professional as permitted by state law. All mental health services must be provided under appropriate supervision and consultation requirements as set forth by state law.

- Licensed Psychologist: Psychologist shall mean an individual licensed to engage in the practice of psychology in this or another jurisdiction. The terms certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.
- Licensed Special Psychologist: An individual who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not certified in clinical psychology. Such individual shall be issued a special license to practice psychology that continues to require supervision by a licensed psychologist or qualified physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health services without supervision.

- Licensed Mental Health Practitioner: An individual licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified physician or a licensed psychologist.

Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, injury, or deformity, diagnosing major mental health conditions or disorders except in consultation with a qualified physician or a licensed psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified physician or licensed psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified physician or licensed psychologist.

Mental Health – A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV or any subsequent version).

Noncovered Services – Services that are not payable under the Plan.

Out-of-Network Allowance – An amount used to calculate payment for covered services to an Out-of-Network provider.

Out-of-Network Provider – A health care provider (hospital, physician or other health care provider) of health care services who has **not** contracted with us to provide services as a part of a preferred provider network.

Out-of-Pocket Maximum - The maximum amount a participant pays for covered expenses in a calendar year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Outpatient – An individual who is not admitted for inpatient care, but is treated in the outpatient department of a hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a physician's office, or at home. Ambulance services are also considered outpatient.

Outpatient Programs – An organized set of resources and services for a substance abusive or mentally ill population, administered by a certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and outpatient programs which provide primary treatment for mental illness or substance dependence and abuse must be provided in a facility which is licensed by the Department of Health and Human Services regulation and licensure, (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include residential treatment programs or day rehabilitation programs for mental illness or residential treatment programs, halfway house or methadone maintenance programs for substance dependence and abuse.

Participant (s) - An employee or dependent or a participating COBRA Beneficiary meeting the eligibility requirements for coverage as specified in the Plan and properly enrolled in the Plan. The term may also include retirees if such coverage is provided under this Plan.

Physical Rehabilitation – The restoration of an individual who was disabled as the result of an injury or an acute physical impairment to a level of function which allows that individual to live as independently as possible. An individual is disabled when such individual has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Physician – Any individual holding a license and duly authorized to practice medicine and surgery.

Plan Administrator – The Plan Administrator is defined as Transit Authority of the City of Omaha, dba, METRO.

Post-Service Claim – Any claim which is not a preservice claim. The information required to process a post-service claim includes: first and last name of the claimant, identification number, date of service, itemized statement describing the service, the diagnosis, the amount charged for the care and the provider's full name.

PPACA - The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Preferred Provider – A health care provider (hospital, physician or other health care provider) who has contracted to provide services who is a preferred provider with the PPO network.

Preferred Provider Organization – A panel of hospitals, physicians and other health care providers who belong to a network of preferred providers, which agrees to more effectively manage health care costs.

Pregnancy – Includes obstetrics, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections or other conditions or complications caused by pregnancy. Pregnancy also includes a condition or complication caused by pregnancy, but separate from, and not part of the pregnancy. It occurs prior to the end of the pregnancy and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of pregnancy.

Pre-Service Claim – Any claim for a benefit under the contract with respect to which the terms of the contract require approval of the benefit in advance of obtaining medical care and failure to do so will cause benefits to be denied or reduced.

Primary Care Physician – A physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics / gynecology, general pediatrics or family practice.

Prior Authorization - Prior authorization determines whether a proposed treatment is covered by the Plan. A provider or a participant may submit information to the claims administrator regarding a proposed service to determine if and at what level the service is covered by the Plan.

Private Duty Nursing – Continuous nursing care (beyond the accepted definition of a skilled nursing visit) in homes or facilities. Private Duty Nursing is primarily non-skilled in nature but may include skilled services and is generally provided to chronically ill patients over the long term.

Prosthetics – devices used as an artificial substitute to replace a missing natural part of the body.

Qualified Beneficiary – Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Qualifying Event – The circumstances that entitle individuals to elect COBRA coverage.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) - Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Reasonable and Appropriate – An amount of fees that, limited to covered expenses, which are identified as eligible for payment by the Plan Administrator in accordance with the terms of this Plan. "Reasonable and Appropriate" amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]);
- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS);

- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care);
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings);
- Medicare cost data as reflected in the applicable individual provider's cost report(s);
- The fee(s) which the provider most frequently charges the majority of patients for the service or supply;
- Amounts the provider specifically agrees to accept as payment in full either through direct negotiation, through a preferred provider organization (PPO) network or through a designated provider access arrangement;
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply; and
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).

Furthermore, Reasonable and Appropriate shall be limited to those claims that, in the administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of illness or injury not unreasonably caused by the treating provider. Determination that fee(s) or services are therefore Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable and Appropriate, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Residential Treatment Program – Services or a program for individuals with behavioral health disorders organized and staffed to provide both general and specialized nonhospital-based interdisciplinary inpatient services 24 hours a day, seven days a week with oversight by a physician. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities, such as a wing of a hospital. Residential Treatment Programs may include nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Services – Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

Sexual Dysfunction (sexual malfunction, sexual disorder or impotence) - Difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm.

Skilled Nursing Facility - A level of care that includes services that can only be performed safely and correctly by either a registered nurse or a licensed practical nurse.

Special Enrollee – An eligible individual who enrolls for coverage during a special enrollment period, as further described in the contract.

Special Enrollment Period – A period of time during which a special enrollee is allowed to enroll because of a loss of coverage, an adoption, placement for adoption, birth or marriage, without being considered a late entrant, subject to certain criteria as further described in the contract.

Specialist – A physician who has a majority of his or her practice in fields other than internal or general medicine, obstetrics / gynecology, general pediatrics or family practice.

Substance Dependence and Abuse – Alcoholism or drug dependence / abuse.

Substance Dependence and Abuse Treatment Center – A facility licensed by the Department of Health and Human Services regulation and licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not licensed as a hospital, but provides inpatient or outpatient care, treatment, services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of substance dependence or abuse.

Summary of Benefits – A summarized document which provides information such as copayments, deductibles, percentages payable, special benefits, maximums and limitations of coverage, and the type of membership unit selected.

Treating Physician – A physician who has personally evaluated the patient. This may include a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim - A claim for medical care or treatment for which the application of time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. Would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent Care Facility – A facility, other than a hospital, that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms.

WHCRA - The Women's Health and Cancer Rights Act of 1998, as amended.

Work-Hardening Therapy – Physical therapy or similar services provided primarily for strengthening an individual for purposes of his or her employment.

Adoption of the Plan

The Transit Authority of the City of Omaha, dba, METRO Employee Benefit Plan, as stated herein, is hereby adopted as of January 1, 2018.
This document constitutes the basis for administration of the Plan.

Transit Authority of the City of Omaha, dba, METRO:

Signature: _____ Title: _____

Printed Name: _____ Date: _____