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**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**HIGH PLAINS EDUCATIONAL COOPERATIVE #611  
EMPLOYEE HEALTH BENEFIT PLAN**

**EFFECTIVE DATE: OCTOBER 1, 1994**

**RESTATEMENT DATE: OCTOBER 1, 2021**

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## INTRODUCTION

This document is a description of High Plains Educational Cooperative #611 Employee Health Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

***It is the responsibility of the Plan to inform EBMS of any state mandates that would be applicable to the Plan and if there are any benefit changes as a result.***

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

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedure section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

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

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

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

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

**Covered Charges.** Explains when the benefit applies and the types of charges covered.

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

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

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

**How to Submit a Claim.** Explains the rules for filing claims and the claim appeal process.

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

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

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

## SCHEDULE OF BENEFITS

### MEDICAL BENEFITS

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

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.

### PROVIDER INFORMATION

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

Therefore, when a Plan Participant uses a Participating Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Participating Provider is used. It is the Plan Participant's choice as to which provider to use.

To access a list of Participating Providers, please refer to the Participating Provider Organization (PPO) website and/or toll free number listed on the **High Plains Educational Cooperative #611 Employee Health Benefit Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the PPO that the provider is a participant in this organization.

**Note:** The Sutter Health System network is not a Participating Provider under this Plan. Services rendered by a Sutter Health System network provider will be payable subject to the Non-Participating Provider benefit level as stated in the Schedule of Benefits.

**Under the following circumstance, the higher Participating Provider payment will be made for Non-Participating Provider services:**

- If there is not a Participating Provider within 20 miles of where the Plan Participant resides, the Plan Participant can seek care at a Non-Participating Provider.

### DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not subject to the deductible).

Each **January 1st**, a new deductible amount is required. The deductible will apply toward the maximum out-of-pocket amount. However, Covered Charges incurred in, and applied toward the individual deductible in the last three months (**October, November, and December**) of the Calendar Year will only be applied to the individual deductible (and does not apply to the family deductible) in the next Calendar Year as well as the current Calendar Year. The maximum out-of-pocket amount will not carry forward to the next Calendar Year.

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

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

Copayments, including Prescription Drug copayments, *will not apply* toward the deductible.

Copayments, including Prescription Drug copayments, *will apply* to the maximum out-of-pocket amount.

**Coinsurance** is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Plan Participant's responsibility until the maximum out-of-pocket amount is reached. Coinsurance *does not apply* to the deductible and *does not* include copayment amounts.

Once the Plan has made the applicable benefit payment as shown in the Schedule of Benefits, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 70%, the Plan Participant's responsibility (or coinsurance) is 30%.

## **MAXIMUM OUT-OF-POCKET AMOUNT**

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

## MEDICAL BENEFITS SCHEDULE

|                                                                                                                                                                                                                                                                                                                                                                                                       | PARTICIPATING PROVIDERS                                                                       | NON-PARTICIPATING PROVIDERS                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Claims should be received by the Claims Administrator within <b>365 days</b> from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.                                                                                                                  |                                                                                               |                                                                                               |
| The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.                                                                                                                                                                         |                                                                                               |                                                                                               |
| DEDUCTIBLE, PER CALENDAR YEAR                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                               |
| Per Plan Participant                                                                                                                                                                                                                                                                                                                                                                                  | \$800                                                                                         | \$1,200                                                                                       |
| Per Family Unit                                                                                                                                                                                                                                                                                                                                                                                       | \$1,200                                                                                       | \$2,000                                                                                       |
| <i>Note: Participating and Non-Participating Provider deductibles will apply to each other.</i>                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                               |
| MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                               |
| Per Plan Participant                                                                                                                                                                                                                                                                                                                                                                                  | \$1,600                                                                                       | \$2,800                                                                                       |
| Per Family Unit                                                                                                                                                                                                                                                                                                                                                                                       | \$2,800                                                                                       | \$4,400                                                                                       |
| <i>Note: Participating and Non-Participating Provider maximum out of pocket amounts will apply to each other.</i>                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                               |
| The Plan will pay the designated percentage of Covered Charges until the maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.                                                                                                                                               |                                                                                               |                                                                                               |
| The following charges do not apply toward the maximum out-of-pocket amounts and are never paid at 100%. <ul style="list-style-type: none"><li>• Amounts over the Allowable Charge.</li><li>• Ineligible amounts.</li><li>• Discounts, coupons, Pharmacy discount programs, or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.</li></ul> |                                                                                               |                                                                                               |
| COVERED CHARGES                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                               |
| <b>Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating Providers.</b>                                                                                                     |                                                                                               |                                                                                               |
| Hospital Services                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                               |
| Room and Board                                                                                                                                                                                                                                                                                                                                                                                        | 70% after deductible<br>the semiprivate room rate                                             | 40% after deductible<br>the semiprivate room rate                                             |
| Intensive Care Unit                                                                                                                                                                                                                                                                                                                                                                                   | 70% after deductible<br>Hospital's ICU Charge                                                 | 40% after deductible<br>Hospital's ICU Charge                                                 |
| Outpatient Surgical Center /<br>Outpatient Hospital Services                                                                                                                                                                                                                                                                                                                                          | 70% after deductible                                                                          | 40% after deductible                                                                          |
| Emergency Room Services                                                                                                                                                                                                                                                                                                                                                                               | 70% after deductible                                                                          |                                                                                               |
| Urgent Care Services                                                                                                                                                                                                                                                                                                                                                                                  | 70% after deductible                                                                          | 40% after deductible                                                                          |
| Skilled Nursing Facility                                                                                                                                                                                                                                                                                                                                                                              | 70% after deductible<br>the facility's semiprivate room rate<br>30 days Calendar Year maximum | 40% after deductible<br>the facility's semiprivate room rate<br>30 days Calendar Year maximum |
| Ambulance Services                                                                                                                                                                                                                                                                                                                                                                                    | 70% after deductible                                                                          |                                                                                               |
| Physician Services                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                               |
| Inpatient visits                                                                                                                                                                                                                                                                                                                                                                                      | 70% after deductible                                                                          | 40% after deductible                                                                          |
| Office visits                                                                                                                                                                                                                                                                                                                                                                                         | 70% after deductible                                                                          | 40% after deductible                                                                          |
| Surgery                                                                                                                                                                                                                                                                                                                                                                                               | 70% after deductible                                                                          | 40% after deductible                                                                          |
| Second and third surgical opinion                                                                                                                                                                                                                                                                                                                                                                     | 70%, no deductible applies                                                                    | 40%, no deductible applies                                                                    |
| Allergy services and treatment                                                                                                                                                                                                                                                                                                                                                                        | 70% after deductible                                                                          | 40% after deductible                                                                          |
| <i>Note: Participating or Non-Participating Provider diagnostic testing (labs and images) related to a Participating Provider visit and submitted with the same date of service as the visit will be eligible for reimbursement under the Participating Provider visit benefit.</i>                                                                                                                   |                                                                                               |                                                                                               |
| Chemotherapy and Radiation Treatment                                                                                                                                                                                                                                                                                                                                                                  | 70% after deductible                                                                          | 40% after deductible                                                                          |

|                                                                                                                                                                                                                                                                                            | <b>PARTICIPATING PROVIDERS</b>                                                                                                                                                                                                                                                | <b>NON-PARTICIPATING PROVIDERS</b>                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| <b>Chiropractic Services</b>                                                                                                                                                                                                                                                               | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Diagnostic Testing (X-ray &amp; Lab)</b>                                                                                                                                                                                                                                                | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Imaging Services (MRI, CT/PET scans, etc.)</b>                                                                                                                                                                                                                                          | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Dialysis Services</b>                                                                                                                                                                                                                                                                   | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Durable Medical Equipment, Orthotics and Prosthetics</b>                                                                                                                                                                                                                                | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Home Health Care</b>                                                                                                                                                                                                                                                                    | 70% after deductible<br>30 visits Calendar Year maximum                                                                                                                                                                                                                       | 40% after deductible<br>30 visits Calendar Year maximum |
| <b>Home Infusion Therapy / Infusion Therapy</b>                                                                                                                                                                                                                                            | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Hospice Care</b>                                                                                                                                                                                                                                                                        | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| Bereavement Counseling                                                                                                                                                                                                                                                                     | 70% after deductible<br>3 visits per Lifetime maximum                                                                                                                                                                                                                         | 40% after deductible<br>3 visits per Lifetime maximum   |
| <b>Mental Disorders and Substance Abuse Treatment</b>                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                               |                                                         |
| Inpatient Services                                                                                                                                                                                                                                                                         | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| Outpatient Services                                                                                                                                                                                                                                                                        | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| Office Visits                                                                                                                                                                                                                                                                              | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <i><b>Note:</b> Participating or Non-Participating Provider diagnostic testing (labs and images) related to a Participating Provider visit and submitted with the same date of service as the visit will be eligible for reimbursement under the Participating Provider visit benefit.</i> |                                                                                                                                                                                                                                                                               |                                                         |
| <b>Organ Transplants</b>                                                                                                                                                                                                                                                                   | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <i><b>Note:</b> Please see the Covered Charges section for additional information regarding this benefit.</i>                                                                                                                                                                              |                                                                                                                                                                                                                                                                               |                                                         |
| <b>Pregnancy</b>                                                                                                                                                                                                                                                                           | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| Routine prenatal office visits                                                                                                                                                                                                                                                             | 40% of Covered Charges of the global maternity fee will be payable at 100%, no deductible applies; thereafter, subject to 70% after deductible;<br><b>OR, if billed separately, 100% of the routine prenatal office visits will be payable at 100%, no deductible applies</b> | 40% after deductible                                    |
| <i><b>Note:</b> Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits.</i>                                                                                                                        |                                                                                                                                                                                                                                                                               |                                                         |
| <b>Routine Well Newborn Nursery Care (while Hospital confined at birth)</b>                                                                                                                                                                                                                | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Rehabilitation Therapy</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                               |                                                         |
| Inpatient services                                                                                                                                                                                                                                                                         | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| Outpatient services (Occupational, Physical and Speech Therapy)                                                                                                                                                                                                                            | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |
| <b>Temporomandibular Joint Syndrome (TMJ)</b>                                                                                                                                                                                                                                              | 70% after deductible                                                                                                                                                                                                                                                          | 40% after deductible                                    |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PARTICIPATING PROVIDERS                                        | NON-PARTICIPATING PROVIDERS                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------|
| <b>Preventive Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                |                                                         |
| Routine Well Care (birth through adult)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 100%, no deductible applies                                    | 40% after deductible                                    |
| <p><b>Routine Well Care Services</b> will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), unless otherwise specifically stated in this Schedule of Benefits, and which can be located using the following website:</p> <p><a href="http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations">http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations</a></p> <p><b>Routine Well Care Services will include, but will not be limited to, the following routine services:</b><br/>Office visits, routine physical exams, prostate screening, Prostate Specific Antigen (PSA), all immunizations, routine well child care examinations, routine lab and x-ray services, routine colonoscopy, and routine flexible sigmoidoscopy.</p> <p><b>Note:</b> If applicable, this Plan may comply with a state vaccine assessment program.</p> <p><b>Note:</b> All vaccines/immunizations covered by the Plan will be payable under the Participating Provider benefit level.</p> <p><b>Women's Preventive Services</b> will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), unless otherwise specifically stated in this Schedule of Benefits, and which can be located using the following websites:</p> <p><a href="http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a>; and</p> <p><a href="http://www.hrsa.gov/womens-guidelines">http://www.hrsa.gov/womens-guidelines</a></p> <p><b>Women's Preventive Services, will include, but will not be limited to, the following routine services:</b><br/>Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (this does not include birthing classes), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.</p> |                                                                |                                                         |
| Obesity Interventions for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 100%, no deductible applies<br>26 visits Calendar Year maximum | 40% after deductible<br>26 visits Calendar Year maximum |
| <b>Note:</b> Refer to Obesity Interventions benefit listed in the Covered Charges section for more information.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                |                                                         |
| <b>All Other Covered Charges</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 70% after deductible                                           | 40% after deductible                                    |

## PREScription DRUG BENEFIT SCHEDULE

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

### Retail Pharmacy

Copayment per prescription – limited to a 34-day supply

|                                       |      |
|---------------------------------------|------|
| Generic drugs.....                    | \$10 |
| Formulary Brand Name drugs .....      | 40%  |
| Non- Formulary Brand Name drugs ..... | 50%  |

### Mandatory Specialty Pharmacy Program

Copayment per prescription - limited to a 30-day supply

|                                       |      |
|---------------------------------------|------|
| Generic drugs.....                    | \$10 |
| Formulary Brand Name drugs .....      | 40%  |
| Non- Formulary Brand Name drugs ..... | 50%  |

*Refer to the Prescription Drug Benefits section for more information regarding the Mandatory Specialty Pharmacy Program.*

### miRx Mail Order Pharmacy

Copayment per prescription – limited to a 90-day supply

|                                       |      |
|---------------------------------------|------|
| Generic drugs.....                    | \$30 |
| Formulary Brand Name drugs .....      | 40%  |
| Non- Formulary Brand Name drugs ..... | 50%  |

**Refer to the Prescription Drug Section for details on the Prescription Drug benefit.**

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

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

### **ELIGIBILITY**

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

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

- (1) is a full-time administrator, certified teacher, para educator, board employee with High Plains Educational Cooperative #611, or office staff of the Employer working at least 30 hours per week and is on the regular payroll of the Employer for that work.

If the covered Employee is hired during the school year, the covered Employee is eligible for coverage the first day of the calendar month following the month in which the covered Employee meets all eligibility requirements under this Plan.

If the covered Employee is hired at the beginning of the school year, he/she will be eligible for coverage on October 1<sup>st</sup> after the covered Employee is hired and is serving as a full-time administrator, certified teacher, board employee with High Plains Educational Cooperative #611, or office staff working at least 30 hours per week and is on the regular payroll of the Employer for that work.

- (2) is a Retired Employee of the Employer. Please refer to the separate Retirement Coverage provision for more information.
- (3) is in a class eligible for coverage.
- (4) completes the employment Waiting Period of 60 consecutive days as an Active Employee. A “Waiting Period” is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

**Note:** Temporary or seasonal personnel are not eligible to participate in this Plan. Teachers working less than full-time will not be eligible to participate in this Plan.

The Employer has elected to use the monthly measurement method for all of its Employees to determine full-time status. An Employee must average or be expected to average the required minimum hours of service established by the Employer each week to become eligible for coverage. An Employee’s initial measurement period begins the first day of the month following the date of hire. To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

For more information on benefit measurement periods, contact the Employer’s Human Resources Department.

### **RETIREMENT COVERAGE (KANSAS STATUTE 12-5040)**

If you have been employed with High Plains Educational Cooperative #611 for not less than 10 years and are eligible to retire, you and your Dependents may receive retirement benefits through the Plan pursuant to Kansas Statute No. 12-5040.

**If you elect to continue your benefits through this Plan through retirement coverage, you must file a written application with the Treasurer of High Plains Educational Cooperative #611 within 31 days of your retirement.**

Cost of this retirement coverage is 125% of the premium cost for other similarly situated Employees. You will pay the entire cost of this coverage for yourself and any Dependents.

Coverage under this provision may cease upon any of the following events:

- (1) The Retired Employee attaining age 65;
- (2) The Retired Employee failing to make required premium payments within 30 days of the due date; or
- (3) The Retired Employee and any covered Dependents becoming covered or becoming eligible to be covered under a plan of another employer or exceeding the limiting age of dependence.

For the purposes of this provision, “Retired Employee” means any Employee who has terminated employment and is receiving a retirement or disability benefit for service to High Plains Educational Cooperative #611 when employment is terminated.

**For additional information regarding this provision and benefits under this statute, please contact the Treasurer.**

**Note:** Upon retirement, an Employee can choose between COBRA Continuation Coverage or continuing coverage under the terms of the Plan as a Retiree, if the Retiree satisfies the criteria as set forth above. If the Employee is eligible and chooses to continue coverage under the terms of the Plan as a Retiree, they will forfeit their right to elect COBRA Continuation Coverage at a later date.

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

- (1) A covered **Employee's or Retiree's Spouse** and **children** from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term “**Spouse**” shall mean a covered Employee's or Retiree's legal spouse who is a resident of the same country in which the covered Employee resides. Such spouse must have met all requirements of a valid marriage contract in the state of marriage of such parties. *This definition does not include common-law marriage or coverage of domestic partners.* **The Plan Administrator may require documentation proving a legal marital relationship.**

The term “**children**” shall include the covered Employee or Retiree's natural children, adopted children, children placed with a covered Employee or Retiree in anticipation of adoption, or step-children who reside with the covered Employee or covered Retiree in a parent/child relationship.

**Note:** *Dependent grandchildren who were covered by the Plan prior to October 1, 1995 shall remain eligible for coverage subject to all other eligibility provisions. All other dependent grandchildren who are not legally adopted are not otherwise eligible for coverage under this Plan.*

If a covered Employee or Retiree is the **Legal Guardian** and the child or children reside with the covered Employee or Retiree in a parent/child relationship, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Plan Participant may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

**The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.**

- (2) A covered Dependent child who reaches the limiting age and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

**These persons are excluded as Dependents:** Other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; or any person who is covered under the Plan as an Employee or Retiree.

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

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

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

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

## FUNDING

**Cost of the Plan.** High Plains Educational Cooperative #611 shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The covered Employee must pay the full Employee monthly cost share for coverage to continue. If the covered Employee fails to pay the full Employee monthly cost share in a timely manner, High Plains Educational Cooperative #611 will provide a 31-day extension for a covered Employee to make the full Employee monthly cost share. If the covered Employee fails to pay the full Employee monthly cost share after the 31-day extension has expired, the Employee's coverage will be terminated.

Retirees pay the cost of coverage for Retiree and Dependent coverage.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Employee will be required to enroll for Dependent coverage also.

**Enrollment Requirements for Newborn Children.** A newborn child of a covered Employee or Retiree is **not** automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the "Timely Enrollment" section below, there will be no payment from the Plan and the parents will be responsible for all costs.

## TIMELY OR LATE ENROLLMENT

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

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

- (2) **Late Enrollment** – An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. *Coverage begins as stated in the Open Enrollment section below.*

**Open Enrollment** – Each August and September the Employer will hold an open enrollment period. During this open enrollment period, any eligible Employee and their eligible Dependents who are Late Enrollees may enroll in the Plan, or a covered Employee or his/her covered Dependent(s) may term his/her coverage in this Plan.

Benefit choices made during the open enrollment period will become effective **October 1st**.

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

- (3) **Enrollment Following A Benefit Measurement Period** – Employees who were determined to be full-time Active Employees during the applicable measurement period and their eligible Dependents may enroll in the Plan the first day of the first full calendar month of the following stability period. To the extent previously satisfied, the employment Waiting Period will be considered satisfied.

## SPECIAL ENROLLMENT RIGHTS

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

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

**The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

## SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. *(Note: A Retired Employee who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment, nor will the Retired Employee's eligible Spouse or Dependent children.)*

- (1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions *(Note: The following provisions will not be applicable to a Retired Employee and/or their Spouse or Dependent children):*
  - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c) Either (i) the other coverage was COBRA coverage, and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin as of the date of loss.
  - (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin as of the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- (i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).
- (ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- (iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual).
- (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

- (2) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:
  - (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), or

- (b) The Retired Employee is a participant under this Plan; and
- (c) A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption,

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

The Special Enrollment Period for newly eligible Dependents is a period of 31 days and begins the date of the marriage, birth, adoption, or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee or Retired Employee must request enrollment during this 31-day period. *If the Retired Employee is not enrolled at the time of the event, this Special Enrollment right will not be applicable.*

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

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

### **(3) Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

Employees and their Dependent children who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility if:

- (a) The Dependent child ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- (b) The Dependent child becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will be the first day of the first calendar month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

**For more information regarding special enrollment rights, contact the Plan Administrator.**

## EFFECTIVE DATE

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

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

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

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

## TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the Employee's Eligible Class is terminated;
- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes or if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
- (5) August 31<sup>st</sup> of the year of termination of employment for teachers completing a school year contract;
- (6) If an Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or
- (7) As otherwise specified in the Eligibility section.

**Note:** Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Coverage.

**Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

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

**Rehiring a Terminated Employee.** A terminated Employee who is rehired prior to the end of a 26 week period after the date of termination will be credited with time met towards the employment Waiting Period as of the date of termination. Coverage will begin the first day of the first calendar month following the date of rehire or the first day of the first calendar month following completion of the Waiting Period.

A terminated Employee who is rehired after an absence of at least four but less than 26 weeks and longer than the period worked prior to the absence will not be credited with any time met towards the employment Waiting Period as of the date of termination and will be considered a new hire.

Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

However, if the Employee is returning to work directly from COBRA coverage, this Employee will be credited with time met towards the employment Waiting Period as of the date the Employee elected COBRA Continuation Coverage.

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

- (1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:
  - (a) The 24-month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Retired Employee Coverage Terminates.** Retired Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the Retired Employee reaches age 65 years;
- (3) The date the Retired Employee and any covered Dependents become covered or become eligible to be covered under a plan of another employer, or exceeding the limiting age of dependence;
- (4) The date the Retired Employee fails to make required premium payments within 30 days of the due date; or
- (5) If a Retired Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Retired Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated;
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.);
- (4) The last day of the calendar month in which a Dependent child ceases to be a Dependent (as defined in the Eligible Classes of Dependents section under the Plan). (See the section entitled COBRA Continuation Coverage.);
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
- (6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or
- (7) As otherwise specified in the Eligibility section.

**Note:** Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

## MEDICAL BENEFITS

Medical benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness while the Plan Participant is covered for these benefits under the Plan.

Claims should be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

## COVERED CHARGES

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

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

If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semi-private room rate in the geographic area. The private room charge will be allowed as a Covered Charge if quarantine is Medically Necessary.

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

- (2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness and will be payable as shown in the Schedule of Benefits.

Amniocentesis will be a Covered Charge only when the attending Physician certifies that the procedure is Medically Necessary.

**Note:** Routine prenatal office visits will be payable as shown under the Pregnancy benefit in the Schedule of Benefits. The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

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

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
- (a) the Plan Participant is confined as a bed patient in the facility; and
  - (b) the attending Physician certifies that the confinement is deemed Medically Necessary; and
  - (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these facilities are payable up to the limits as shown in the Schedule of Benefits.

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

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

- (a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge allowed for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for outpatient nursing care are those shown below under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

- (6) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

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

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

Bereavement counseling services by a healthcare provider acting within the scope of his or her license for the Plan Participant's immediate family (covered Employee, covered Spouse, and/or other covered Dependent children). Bereavement services must be furnished within six months after the Plan Participant's death. Charges for bereavement counseling are subject to the limits as described in the Schedule of Benefits.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Allergy Testing and Treatment.** Covered Charges for allergy testing and treatment, including injections and serum.
- (b) **Ambulance Services.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, unless the Plan Administrator finds a longer trip was Medically Necessary.
- (c) **Anesthesia Services** when performed by a healthcare provider acting within the scope of his or her license in connection with a surgical procedure.
- (d) **Blood.** Covered Charges for blood and the administration of transfusions, blood derivatives that are not donated or replaced. Charges do not include the expense of the donor.
- (e) **Breast Pump, Breast Pump Supplies, Lactation Support, and Counseling.**

**Breast pump, breast pump supplies**

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/Hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/Hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits.

**Note:** *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Participating Provider benefit level only for the purposes of this benefit.*

*The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.*

### **Lactation support and counseling**

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

**Note:** *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits at the Participating Provider payment for non-Participating Provider services for the purposes of this benefit.*

- (f) **Cardiac Rehabilitation** as deemed Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (g) **Chemotherapy or Radiation Treatment** with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to CareLink should include the Plan Participant's Plan of Care and treatment protocol. Pre-notification of services should occur at least seven days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following numbers:

Toll Free in the United States: (866) 894-1505

Local Call in Billings, Montana: (406) 245-3575

*A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to Medical Necessity, exclusions, and limitations in effect when services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.*

- (h) **Chiropractic Services.** Chiropractic services involving only the detection and correction of distortion, misalignment, or dislocation of the spinal column. Treatment of other diagnoses will not be covered. A treatment plan may be requested from the provider from time to time. If a review of the treatment plan shows a less than favorable prognosis for the Plan Participant, benefits may be suspended.
- (i) **Circumcision.** Circumcision will only be covered during the initial Hospital confinement of a newborn unless a delay is Medically Necessary.
- (j) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:
  - The clinical trial is registered on the National Institute of Health (NIH) maintained web site [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as a Phase I, II, III, or IV clinical trial;
  - The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol;"
  - The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
  - The trial is approved by the Institutional Review Board of the institution administering the treatment; and

- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

**Routine patient services do not include, and reimbursement will not be provided for:**

- The Investigational service, supply, or drug itself;
  - Services or supplies listed herein as Plan Exclusions;
  - Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g., monthly CT scans for a condition usually requiring only a single scan); and
  - Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item, or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.
- (k) **Contact Lenses.** Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, required following cataract surgery or to replace the human lens lost through intraocular surgery.
- (l) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs), implants, injections, and any related Physician and facility charges (including complications), and including insertion and removal when applicable. Covered Charges will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits.

Refer to the separate Prescription Drug Benefits section of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables, and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

- (m) **Dialysis.** Expenses for the treatment of kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility, or for expenses in an outpatient facility or in the Plan Participant's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member.

For renal dialysis treatments associated with an inpatient hospitalization, the Plan Administrator has the discretionary authority to negotiate a contract rate or other discounting arrangement on the entire inpatient claim. For additional coverage details specific to "Renal Dialysis Services", refer to the Coordination of Benefits section.

Renal dialysis services include dialysis, facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

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

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

(n) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant; and
- Does NOT have significant non-medical uses (i.e., air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.
- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

Insulin infusion pumps will be limited to one per Lifetime.

**The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.**

(o) **Genetic Testing.** Genetic testing will be a Covered Charge only when there is a history of genetic disorder in the immediate family.

- (p) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy, and the collection, analysis, and reporting of the results of laboratory testing services required to monitor a response to therapy.
- (q) **Infusion Therapy.** Medically Necessary Physician-prescribed administration of fluids, nutrition, or medication by intravenous or gastrointestinal (enteral) infusion or by intravenous injection. Covered Charges under this benefit include Prescription Drugs, nursing, and administrative services.
- (r) **Intravenous Drugs and Solutions,** including administration.
- (s) **Laboratory Studies.** Covered Charges for diagnostic lab testing and services.
- (t) **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies, and treatment of Mental Disorders and Substance Abuse.
- (u) **Morbid Obesity.** Charges for diagnostic testing, surgical, and non-surgical procedures for the treatment of Morbid Obesity when deemed Medically Necessary.

A pre-notification of services, by the Plan Participant is strongly recommended for either inpatient or outpatient surgical procedures and will require the following documentation including, but not limited to, a written Plan of Care by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met.

Covered Charges will include Physician's office visits, related laboratory testing, surgical treatment, including complications whether direct or indirect, and non-surgical treatment, including dietary counseling.

Repeat surgical procedures or revisions to surgical procedures may be considered under this Plan only if deemed Medically Necessary.

The measurement of Body Mass Index (BMI) as defined under this Plan or a BMI of 35 or greater with any comorbid conditions that are expected to improve, reverse, or be limited by this surgical treatment and which must be documented in a record or letter of Medical Necessity must demonstrate the diagnosis of Morbid Obesity.

*A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan including, but not limited to, Medical Necessity, exclusions, and limitations in effect when charges are incurred. A pre-notification is not required as a condition to paying benefits and cannot be appealed.*

- (u) **Mouth, Teeth, and Gums.** Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
  - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
  - Emergency repair due to Injury to sound natural teeth, including replacement of such teeth and any related x-rays.
  - Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.

Hospital confinement expenses for dental services will be a Covered Charge if the attending Physician certifies that hospitalization is necessary to safeguard the health of the Plan Participant. In addition, this benefit shall include coverage for the administration of general anesthesia and Medical Care Facility charges for dental care provided to the following Plan Participants:

- (i) A Dependent child five years of age and under;
- (ii) A Plan Participant who is severely disabled; or
- (iii) A Plan Participant with a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

- (v) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m<sup>2</sup> or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (limited up to 26 visits maximum per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a Covered Charge except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

- (w) **Occupational Therapy** by a health care provider acting within the scope of his or her license. Therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.
- (x) **Organ Transplants.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that are not considered Experimental or Investigational, subject to the following criteria:
  - The transplant must be performed to replace an organ or tissue.
  - Organ transplant benefit period. A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the

beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- Organ procurement limits. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
  - (i) Evaluating the organ or tissue; and
  - (ii) Removing the organ or tissue from the donor

**Note:** Expenses related to the purchase of any organ will not be covered.

As soon as reasonably possible, but in no event more than ten days after a Plan Participant's attending Physician has indicated that the Plan Participant is a potential candidate for a transplant, the Plan Participant or his or her Physician must contact CareLink at (866) 894-1505.

- In the event a Network Provider transplant facility is utilized, benefits will be payable at the Network Provider benefit level.
- In the event a Network Provider transplant facility is unavailable and the providing transplant facility is an Institute of Excellence (IOE) facility, benefits will be payable at the Network Provider benefit level.
- In the event a non-Network Provider transplant facility is utilized and the providing transplant facility is not an IOE facility, benefits will be payable at the non-Network Provider benefit level.

There is no obligation to the Plan Participant to use either a Network Provider or an IOE facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a non-Network Provider and whether or not an IOE facility is utilized.

**Institute of Excellence (IOE).** This is a facility that is contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

### **Special Transplant Benefits**

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

### **Transplant Exclusions**

Coverage for the following procedures, when Medically Necessary, may be provided under the regular medical benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as stated in the Schedule of Benefits:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

- (y) **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, crutches, cervical collars, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

Foot orthotics, orthopedic or corrective shoes, or supportive appliances for the feet **will not** be a Covered Charge.

- (z) **Oxygen.** Covered Charges for oxygen and its administration. Coverage of the rental of equipment required for its use will be payable under the separate Durable Medical Equipment benefit.

- (aa) **Physical Therapy** by a health care provider acting within the scope of his or her license. The therapy must be 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 and will not include massage therapy.

- (bb) **Pre-Admission Testing (PAT)** within seven days of a scheduled inpatient Hospital admission or outpatient surgical procedure.

- (cc) **Prescription Drugs** (as defined). Outpatient Prescription Drug charges will be payable under the separate Prescription Drug Benefits section.

- (dd) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Schedule of Benefits.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) with a grade A or B recommendation, or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

- (ee) **Prosthetic Devices.** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts, including artificial limbs and eyes.

- (ff) **Reconstructive Surgery.** Covered Charges will be payable for cosmetic surgery or reconstructive surgery due to the following:

- Cosmetic or reconstructive surgery when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part;
- Cosmetic or reconstructive repair of an accidental Injury;
- Correction of abnormal congenital conditions or hereditary complications or conditions due to:
  - Cleft lip or palate;
  - Birthmarks on the head or neck;
  - Webbed fingers or toes;
  - Supernumerary digits or toes.

- Reconstructive surgery following a covered mastectomy. Reconstruction following a mastectomy will include reimbursement for:
  - reconstruction of the breast on which a mastectomy has been performed,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  - coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

and in a manner determined in consultation with the attending Physician and the Plan Participant.

- (gg) **Rehabilitation Therapy.** Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

- (hh) **Second Surgical Opinion.** Covered Charges include second surgical opinions. A third surgical opinion will be eligible only if the initial and second surgical opinions vary.
- (ii) **Sleep Disorders.** Care, treatment, services, and supplies in connection with sleep disorders, when deemed Medically Necessary.
- (jj) **Speech Therapy** by a health care provider acting within the scope of his or her license. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a Plan Participant; (ii) an Injury; or (iii) an Illness.
- (kk) **Sterilization Procedures.** Sterilization procedures for female Plan Participants will be payable under the Preventive Care benefit as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
  - Sterilization procedures for male Plan Participants.
- (ll) **Surgical dressings,** splints, casts, and other devices used in the reduction of fractures and dislocations.
- (mm) **Telehealth.** Telehealth services will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.
- (nn) **Temporomandibular Joint Syndrome (TMJ).** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ). This benefit will be coordinated with any applicable dental benefits provided by the Employer or other group coverage plan.

**(oo) Well Newborn Nursery/Physician Care.**

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

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

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

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

**Charges for Routine Physician Care.** The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined, including circumcision, as a result of the child's birth.

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

**(pp) X-rays.** Covered Charges for diagnostic x-rays and imaging services.

## CARE MANAGEMENT SERVICES

### UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.

**Examples of when the Physician and Plan Participant should contact CareLink prior to treatment include:**

- Inpatient admissions to a Hospital;
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities;
- Cancer treatment Plan of Care, administered on an inpatient or outpatient basis;
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery (if applicable under this Plan); and
- Outpatient services as follows:
  - Dialysis
  - Genetic testing
  - Injectables
  - Home Health Care
  - Hospice
  - Durable Medical Equipment (DME) over \$2,000

***All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.***

The Physician or Plan Participant should notify CareLink at least seven days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number, and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The Plan of Care, treatment protocol and/or Informed Consent, if applicable

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital, or attending Physician should notify CareLink within two business days after the admission.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

**Contact the Care Management administrator at:**

**CareLink (406) 245-3575 or 1 (866) 894-1505**

## **PRE-ADMISSION AND POST DISCHARGE CARE CALLS**

A CareLink nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan, and post-discharge follow-up.

## **PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS**

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s). The request for reconsideration should be addressed to:

CareLink  
Attn: Appeals  
7400 West Campus Rd.  
New Albany, OH 43054

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the Medical Necessity, the Experimental/Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

## **CASE MANAGEMENT**

If a Plan Participant has an ongoing medical condition or catastrophic illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

This Plan of Care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

**Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.**

**Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.**

## DEFINED TERMS

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

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

**Allowable Charge** means the amount for a treatment, service, or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

For Covered Charges rendered by a Physician, Hospital, or ancillary provider in a geographic area where applicable law or a governmental authority directs the amount to be paid, the Allowable Charge will mean the amount established by applicable law or governmental authority for the Covered Charge.

In the absence of such network arrangement, negotiated arrangement, controlling law, or governmental directive that establishes the amount to be paid, the Allowable Charge will mean: (i) an amount that does not exceed billed charges for the same treatment, service, or supply furnished in the same geographic area by a provider of like services; and (ii) a reasonable amount established solely and exclusively by the Plan Administrator or its designee; and (iii) (except in circumstances where a provider network arrangement, other discounting or negotiated arrangement is established), an amount that does not exceed two hundred percent (200%) of the Medicare allowed amount, if any.

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

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

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

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

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

**Complications of Pregnancy** are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

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

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

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

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

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

**Employer** is High Plains Educational Cooperative #611.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Infertility** means incapable of producing offspring.

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

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

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

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

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

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

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

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

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

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

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

**Morbid Obesity** is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his or her height squared (in meters).

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

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

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

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

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

**Plan** means High Plains Educational Cooperative #611 Employee Health Benefit Plan, which is a benefits plan for certain Employees of High Plains Educational Cooperative #611 and is described in this document.

**Plan of Care** is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

**Plan Participant** is any Employee, Retiree, or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on October 1<sup>st</sup> and ending on the following September 30<sup>th</sup>.

**Pre-Admission Tests** are tests performed on the Plan Participant or their Dependent prior to confinement as a resident inpatient provided:

- (1) such tests are related to the performance of scheduled surgery;
- (2) such tests have been ordered by a duly qualified Physician after a condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician and confirmed by the Hospital; and
- (3) the Plan Participant or their Dependent are subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the Plan Participant or their Dependent's condition which precludes surgery.

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

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

**Retired Employee (Retiree)** means a former Active Employee of the Employer who retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan any contribution as may be required from the Retired Employee.

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

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

- (7) It is approved and licensed by Medicare.

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

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

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

**Total Disability (Totally Disabled)** means: In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

**Urgent Care Services** means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

## PLAN EXCLUSIONS

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

**The following are not covered under this Plan:**

- (1) **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy.
- (2) **Acupuncture.** Care, treatment, services, and supplies in connection with acupuncture or acupressure.
- (3) **Automatic external defibrillators.** Services and supplies in connection with automatic external defibrillators.
- (4) **Broken appointments.** Charges for broken appointments.
- (5) **Coding guidelines.** Charges for inappropriate coding in accordance with the industry standard guidelines in effect at the time services were received.
- (6) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.
- (7) **Cosmetic surgery or reconstructive surgery.** Charges in connection with cosmetic surgery or reconstructive surgery, except as specifically stated as a benefit under this Plan or as otherwise deemed Medically Necessary.
- (8) **Counseling.** Care and treatment for marital or pre-marital counseling, financial counseling, or religious counseling.
- (9) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care, or domiciliary care consisting chiefly of room and board, except as specifically stated as a benefit under this Plan.
- (10) **Dental services.** Dental services, care, or treatment, except as specifically stated as a benefit under the Plan.
- (11) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit under this Plan.
- (12) **Electrical nerve stimulation** for the relief of pain, or implanted electrical nerve stimulators.
- (13) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.
- (14) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational therapy, or physical therapy if covered by this Plan.
- (15) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental, Investigational, or not Medically Necessary.
- (16) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, orthoptics, vision therapy and supplies. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (17) **Foot care (routine).** Treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease), or as otherwise deemed Medically Necessary.

- (18) **Foreign travel.** Care, treatment, or supplies obtained outside of the U.S., if travel is for the sole purpose of obtaining medical services.
- (19) **Government coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.
- (20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician.
- (21) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids, related supplies, or exams for their fitting.
- (22) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (23) **Hypnosis.** Charges in connection with hypnosis.
- (24) **Illegal acts.** Expenses incurred for Injuries and/or Illnesses sustained during the commission or attempted commission of any criminal or illegal act involving: (1) the use of drugs or alcohol, including but not limited to driving while under the influence of an illegal substance or alcohol; (2) violence or the threat of violence to another person including but not limited to assault or other felonious behavior; or by participating in a riot or public disturbance; (3) the use of a firearm, explosive or other weapon likely to cause physical harm or death if used by a Plan Participant. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition. Determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Plan Participant including, without limitation, acquittal, or failure to prosecute in connection with the acts involved.
- (25) **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence or sexual dysfunction, including penile prosthetic implants and services and/or supplies for the treatment of sexual dysfunction or impotence.
- (26) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.
- (27) **Infertility.** Care, supplies, services, and treatment for Infertility including, but not limited to, medications, surgical treatment for the correction of Infertility, artificial insemination and in vitro fertilization.
- (28) **Laboratory services** when performed by an independent laboratory that is not approved by Medicare.
- (29) **Mailing or sales tax.** Charges for mailing, shipping, handling, postage, conveyance, and sales tax.
- (30) **Massage therapy.** Care, treatment, services, and supplies in connection with massage therapy.
- (31) **Medical reports.** Charges for preparing medical reports (unless requested by the Claims Administrator directly from a medical provider), itemized bills, or claim forms.
- (32) **Motor vehicle accident.** Health services resulting from accidental bodily Injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense payment provision (by whatever terminology used – including such benefits mandated by law) of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Plan.
- (33) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (34) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

- (35) **No Physician recommendation.** Care, treatment, services, or supplies not recommended and approved by a Physician; or treatment, services, or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.
- (36) **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.
- (37) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (38) **Not specified as covered.** Non-traditional medical services, treatments, and supplies which are not specified as covered under this Plan.
- (39) **Nutritional supplements or vitamins.** Charges in connection with nutritional supplements or vitamins, including pre-natal vitamins.
- (40) **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except for Medically Necessary treatment of Morbid Obesity or as otherwise allowed under the separate Obesity Interventions benefit under this Plan.
- (41) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:
- (a) Has waived his/her rights to Workers' Compensation benefits;
  - (b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or
  - (c) The Plan Participant is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.
- (42) **Personal comfort items.** Personal comfort items, personal convenience items, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, non-hospital adjustable beds, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines (i.e., over-the-counter (OTC) medications which do not require a Physician's prescription), and first-aid supplies.
- (43) **Plan design excludes.** Charges excluded by the Plan design or that exceed the limits as mentioned in this document.
- (44) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.
- (45) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.
- (46) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness, or Pregnancy-related condition which is known or reasonably suspected unless such care is specifically covered in the Schedule of Benefits or required by applicable law.
- (47) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury or Illness. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- (48) **Services before or after coverage.** Care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (50) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (51) **Surrogate expenses.** Charges in connection with the use of a surrogate mother or to act as a surrogate.
- (52) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.
- (53) **War.** Any loss that is due to a declared or undeclared act of war.

Claims should be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

## PREScription DRUG BENEFITS

**The Coordination of Benefits provision will not apply at the point of sale to prescriptions purchased at a Participating Pharmacy.**

### PHARMACY DRUG CHARGE

Participating Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **Navitus Health Solutions** is the administrator of the pharmacy drug plan.

**For prescription claims questions or to obtain a claim form please call:**

Navitus Health Solutions – toll-free (866) 333-2757  
Or on the web by logging in to miBenefits at [www.ebms.com](http://www.ebms.com)

**Please submit prescription claim forms to:**

Navitus Health Solutions  
Operations Division – Claims  
P.O. Box 999  
Appleton, WI 54912-0999

Or fax ALL information to (920) 735-5315 or toll-free (855) 668-8550

### COPAYMENTS

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Prescription Drug Benefit Schedule. The copayment amount is a Covered Charge under the medical Plan.

Any one Pharmacy prescription is limited to a 34-day supply.

If a drug is purchased from a Non-Participating Pharmacy, or a Participating Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit his or her prescription receipts directly to **Navitus Health Solutions** for reimbursement less any applicable copayment as shown in the Prescription Drug Benefit Schedule.

### miRx MAIL ORDER DRUG BENEFIT OPTION

The miRx mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the miRx mail order Pharmacy is able to offer Plan Participants significant savings on their prescriptions. Please contact Navitus Health Solutions for more information concerning the miRx mail order Pharmacy.

Any one mail order prescription is limited to a 90-day supply.

**Note:** The miRx mail order drug benefit option is available in certain states only. Please contact the Claims Administrator for more information regarding this benefit.

### MANDATORY SPECIALTY DRUG PROGRAM

**Navitus SpecialtyRx** helps Plan Participants who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. **This program is part of the Pharmacy benefit and is mandatory.**

Any one specialty medication is limited to a 30-day supply.

When a new specialty drug is written for the Plan Participant, the Plan will allow the Plan Participant to purchase **the first 30-day supply** at a local Pharmacy. The specialty medication copayment is payable as shown in the Prescription Drug Benefit Schedule.

## **How to use the Navitus SpecialtyRx program?**

Navitus SpecialtyRx works with our specialty partner to offer services with the highest standard of care. The Plan Participant will get one-on-one service with skilled pharmacists. The pharmacist will answer questions about side effects and give advice to help the Plan Participant stay on course with their treatment. With Navitus SpecialtyRx, delivery of specialty medications is free right to the Plan Participant's door or the Physician's office via FedEx.

Local courier service is available for emergency, same-day medication needs. **To start using Navitus SpecialtyRx, please call toll-free (877) 651-4943.** Navitus SpecialtyRx will work with the Physician for current or new specialty prescriptions.

## **STEP THERAPY PROGRAM**

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines, and well documented clinical studies. This means that in some instances the Plan Participant will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her pharmacy benefit plan.

For a complete list of medications that are subject to Step Therapy protocols, contact Navitus Health Solutions toll-free at (866) 333-2757 about specific pharmacy benefit plan.

What happens when a medication is Medically Necessary, but it is a part of a Step Therapy protocol? If it is Medically Necessary for the Plan Participant to receive a "second step" medication before any "first step" medications have been tried, the Plan Participant's Physician may request coverage of the medication as a medical exception.

## **TABLET SPLITTING PROGRAM**

The Tablet Splitting program saves the Plan Participant money by breaking a higher-strength tablet in half to provide the needed dose. The Plan Participant will receive the same medication and dosage while purchasing fewer tablets and saving on his/her copayment. Medications included in the program are marked with "s" in the Navitus Formulary.

There are two ways to get started with the Tablet Splitting program:

- (1) The Plan Participant should contact his/her prescribing Physician and ask about the RxCENTS program. The prescribing Physician can update the Plan Participant's prescription with the Pharmacy.
- (2) The Plan Participant should ask the Pharmacist to change the Plan Participant's prescription to one that can be split through the Navitus Tablet Splitting program.

Tablet splitting is not required by Navitus but is simply offered to the Plan Participant as a way to help control costs. For questions or to receive a tablet splitter, please contact **Navitus Health Solutions** toll-free at (866) 333-2757.

## **COVERED PRESCRIPTION DRUGS**

*Note: Some quantity limitations and/or prior approval may apply.*

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. A prior authorization will apply to high cost compound medications.

- (3) Insulin and other diabetic supplies, including disposable needles/syringes, testing agents, alcohol swabs, blood glucose monitors, pen needles, lancets, and lancet devices, when prescribed by a Physician.
- (4) Acne medications, when prescribed by a Physician. Prior authorization will apply for Plan Participants over age 35.
- (5) Injectable drugs or any prescription directing administration by injection.

**The following will be covered at 100%, no copayment required for Formulary drugs.**

*Benefits may be subject to prescription Formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Prescription Drug Benefit Schedule. **Contact Navitus Health Solutions toll-free (866) 333-2757 to request coverage of the medication as a non-formulary medical exception.***

- (1) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) for all female Plan Participants with reproductive capacity.

*Refer to the Medical Benefits section of this Plan regarding coverage for intrauterine devices (IUDs), implantables, and injectables.*

- (2) Physician-prescribed tobacco/nicotine cessation products.
- (3) Vaccinations/immunizations when rendered only through a Participating Pharmacy.

***Note:** Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability of an in-store immunization program, age restrictions on service, need for prescription, or hours of service. Please contact Navitus Health Solutions toll-free 1 (866) 333-2757 for more information.*

- (4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance, or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact **Navitus Health Solutions** toll-free (866) 333-2757 for more information regarding which medications are available. **Note:** Age and/or quantity limitations may apply:

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

## **LIMITS TO THIS BENEFIT**

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

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

## EXPENSES NOT COVERED

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

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, including pre-natal vitamins.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless deemed Medically Necessary.
- (8) **Immunization.** Immunization agents or biological sera, except as specifically stated as a benefit under the Prescription Drug Benefits section.
- (9) **Impotence.** A charge for impotence and sexual dysfunction medication.
- (10) **Infertility.** A charge for fertility or Infertility medication.
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan 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.
- (12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
- (13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs. In addition, discounts, coupons, Pharmacy discount programs, or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs will not be a Covered Charge under this Plan.
- (15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over-the-counter (OTC) drugs prescribed by a Physician and as specifically stated as a benefit under this Plan.
- (16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that exceeds the number of refills ordered by the Physician.

## HOW TO SUBMIT A CLAIM

When services are received from a healthcare provider, a Plan Participant should show his or her **EBMS/High Plains Educational Cooperative #611 Employee Health Benefit Plan** identification card to the provider.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) codes and diagnostic codes (ICD) from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**High Plains Educational Cooperative #611, Group #04068**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

**Note:** A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at <http://www.ebms.com>.

## WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, LLC is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefits Management Services, LLC  
P.O. Box 21367  
Billings, MT 59104  
(406) 245-3575 or (800) 777-3575

## WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A “Claim” means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims.

### **Concurrent Care Determination**

**A Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

### **Post-Service Claim**

**A Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

### **Initial Benefit Determination**

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

### **Notice of Adverse Benefit Determination**

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

- (1) Information to identify the claim involved.
- (2) Specific reason(s) for the denial, including the denial code and its meaning.

- (3) Reference to the specific Plan provisions on which the denial was based.
- (4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
- (5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once the Claimant has exhausted all available internal and external review procedures.
- (6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- (7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.
- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.
- (9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

### **Claims Review Procedure – General**

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records, and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon, or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

## **Internal Appeal Procedure**

### **First Level of Internal Review**

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator  
% Employee Benefit Management Services, LLC (EBMS)  
Attn: Claims Appeals  
P.O. Box 21367  
Billings, MT 59104

**An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.**

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

### **Second Level of Internal Review**

If the Claimant does not agree with the Claims Administrator's determination from the first Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Plan Administrator  
% Employee Benefit Management Services, LLC (EBMS)  
Attn: Claims Appeals  
P.O. Box 21367  
Billings, MT 59104

**An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.**

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review.

## **External Review Procedure**

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the 1<sup>st</sup> of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. **Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.**

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered Dependent children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

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

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

- (1) Group or non-group insurance contracts and subscriber contracts;
- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group and non-group coverage through closed panel plans;
- (4) Group-type contracts;
- (5) The medical components of long-term care contracts, such as skilled nursing care;
- (6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;
- (7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;
- (8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident, or non-medical long-term care coverage.

**Allowable Charge(s).** For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" under the Defined Terms section.)

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

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

**Automobile limitations.** When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

- (a) The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

- (b) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated, or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

- 1<sup>st</sup> The plan covering the custodial parent,
- 2<sup>nd</sup> The plan covering the spouse of the custodial parent,
- 3<sup>rd</sup> The plan covering the non-custodial parent, and
- 4<sup>th</sup> The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (e) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or as a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - (d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.
  - (e) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.
  - (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
  - (5) The Plan will pay primary to Tricare to the extent required by federal law.

**Claims determination period.** Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits. This is called the claims determination period.

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

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

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

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

**Exception to Medicaid.** The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

## COORDINATION WITH MEDICARE FOR PERSONS WITH END STAGE RENAL DISEASE (ESRD)

### Medicare Part B Reimbursement

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

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

**If this Plan is secondary, benefits under this Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified by federal law. A Plan Participant who is eligible for Medicare will be considered to be covered for all benefits available under Medicare (Part A and Part B), regardless of whether or not the Plan Participant has actually applied for Medicare coverage.**

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

**Please note:** It is the intent of the Plan to comply with all existing Medicare regulations. If for some reason the information presented in the Plan differs from actual Medicare regulations, the Plan reserves the right to administer claims involving Medicare in accordance with such actual regulations.

## **THIRD PARTY RECOVERY PROVISION**

**(Applicable to ALL benefits available under this Plan)**

### **RIGHT OF SUBROGATION AND REIMBURSEMENT**

#### **WHEN THIS PROVISION APPLIES**

In the event a Plan Participant, his/her Dependents and/or the Plan Participant's guardian or estate (herein referred to as "plan beneficiary") is eligible for benefits under this Plan for medical, dental, or vision care costs as a result of any Injury or Illness and such plan beneficiary initiates a claim with regard to **ANY** potentially liable third party, insurance carrier, or additional entity (other than the Plan) which is or becomes obligated to reimburse to the plan beneficiary the costs of treatment for such Injury or Illness, the Plan shall have a right of subrogation with respect to any full or partial amounts recovered from any and all third parties and shall have a first priority lien on the amount of the benefits paid under this Plan with regard to such Injury or Illness even if the plan beneficiary has not received compensation for all of his or her damages or is not made whole by any such settlement or recovery. This lien shall remain in effect until the Plan is repaid in full.

As a condition to participating in and receiving benefits under this Plan, the plan beneficiary agrees that he/she/it is a fiduciary of the Plan with respect to any recovery that is payable to the Plan hereunder, and also agrees:

- (1) To reimburse the Plan for any such benefits paid to, or on the behalf of, the plan beneficiary when said benefits are recovered, in part or in full, in any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorists' carrier, underinsured motorist carrier, other insurance policies, or funds; and
- (2) To reimburse the Plan for any such benefits paid to or on the plan beneficiary's behalf, is first priority, regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical, disability, or other expenses or damages; and
- (3) To refrain from releasing, without obtaining the Plan's written prior approval, any party, person, corporation, entity, insurance company, insurance policies, or funds that may be potentially liable for or obligated to the plan beneficiary for the Injury or Illness; and
- (4) Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that the plan beneficiary has or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, homeowner's insurance coverage, renter's insurance coverage, medical malpractice insurance coverage, any liability plan coverage, other insurance policies, or funds (herein referred to as "coverage") who has or may have caused, contributed to, or aggravated the Injury or condition for which the plan beneficiary claims an entitlement to benefits under this Plan, regardless of how classified or characterized.
- (5) To cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any monies paid by the Plan for which a third party, their representative, or their insurer, or the plan beneficiary's representative or insurer may be liable including, but not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all efforts by any person to recover any such monies; providing the Plan Administrator with any and all documents, papers, reports and the like regarding demands, litigation, or settlements concerning recovery of monies paid by the Plan; notifying the Plan Administrator of the amount and source of any monies received from third parties from which the Plan may be entitled to repayment.
- (6) Not to engage in any act directly, indirectly, personally, or through third persons to interfere with the Plan's rights to recover hereunder, nor conceal or attempt to conceal the fact that recovery has or will occur.
- (7) To hold in trust for the benefit of the Plan, any and all amounts recovered from any third party, which amounts may be subject to the Plan's subrogation rights as described herein.

## AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT

The plan beneficiary agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a first priority over any funds, full or partial, that the plan beneficiary settles for, recovers or is reimbursed by a third party or coverage to a Plan Participant relative to the Injury or Illness, including a first priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The plan beneficiary agrees to hold any such funds received, regardless if it is a full or partial recovery amount, in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said Injury or Illness, regardless of whether the plan beneficiary has not received compensation for all of his or her damages or is not made whole. If the plan beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or Illness, out of any and all recovery or reimbursement received, the plan beneficiary will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the plan beneficiary.

## PURSUIT OF LEGAL ACTION

If the plan beneficiary decides to pursue a third party or any coverage available to him/her as a result of said Injury or Illness, the plan beneficiary agrees to include the Plan's subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. The Plan shall **not** be liable for any expenses in connection with the recovery (whether fees or costs) of monies unless the Plan shall have agreed in advance in writing to bear a portion or all of the expense thereof. Should a plan beneficiary undertake negotiations or file a lawsuit to recover any kind of damages from any third party or coverage who may be liable for the expenses paid by the Plan, then the plan beneficiary shall, first, notify the Plan Administrator and, second, notify his or her attorney of the Plan's rights and the subrogation trust and lien created by this provision.

In the event the plan beneficiary fails to pursue his or her remedy or claim against any potentially liable third party or coverage, then the Plan shall be subrogated to all rights of such plan beneficiary so that such rights or claims may be prosecuted, compromised, or settled by the Plan in the plan beneficiary's name at the Plan's sole discretion.

If any such action is taken by the Plan, then the plan beneficiary authorizes the Plan to execute any and all documents necessary to pursue said claims in the plan beneficiary's name, and the plan beneficiary agrees to fully cooperate with the Plan in the prosecution of any such claims. The plan beneficiary agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim.

The cooperation of the plan beneficiary shall include a duty to provide information, execute and deliver any acknowledgement and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan. The plan beneficiary agrees and acknowledges that they will respond within 10 days to all inquiries of the Plan regarding the status of any claim that they may have against any third parties or coverage including, but not limited to, no-fault, uninsured, and underinsured. Inquiries by the Plan may include, but are not limited to, requests for accident reports, names and addresses of other parties involved in the accident or occurrence and potential witnesses, information regarding other insurance policies that may apply, including the name and address of agents and adjusters for those insurance policies, information regarding offers of settlement from third parties or their insurers and information regarding any legal proceedings related to the accident or occurrence. The plan beneficiary shall notify the Plan immediately of the name and address of any attorney whom the plan beneficiary engages to pursue any personal Injury claim on his/her behalf.

The plan beneficiary acknowledges that the Plan's subrogation rights shall be considered a first priority claim against **ANY** potentially liable third party and/or coverage and is to be paid before any other claims for the plan beneficiary as the result of such Injury or Illness, regardless if the plan beneficiary has not received compensation for all of his or her damages or is not made whole.

If the Plan or its representative independently pursues and obtains a recovery in the plan beneficiary's name, any amounts recovered shall be used as follows: first, to pay the expenses of collection; second, to reimburse the Plan for any amounts that it has paid or may be required to pay in the future for such Injury or Illness of the plan beneficiary; and, third, any amounts then remaining shall be distributed to the plan beneficiary. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a plan beneficiary pursuing a claim against any third party or coverage. Monies or benefits paid by the Plan shall be repaid in full, notwithstanding any "made whole" or "common fund" or similar law unless a reduction or compromise is agreed to in writing or required pursuant to court order.

## **SUBROGATION AGREEMENT**

Before the Plan shall pay any benefits to or on behalf of a plan beneficiary, the plan beneficiary must execute and return a Subrogation Agreement to the Plan Administrator and supply other reasonable information and assistance as may be requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator, no benefits will be payable under the Plan with respect to costs incurred in connection with such Injury or Illness unless and until claims for such costs have been submitted to and paid by any potentially liable third party and/or coverage to the plan beneficiary for such Injury or Illness. In that regard, the plan beneficiary must provide the Plan Administrator with proof of payment by such other party before any non-reimbursed costs relating to the Injury or Illness will be considered for coverage by the Plan. Nothing in this paragraph shall limit the Plan's subrogation rights.

The Plan Administrator retains sole and final discretionary authority to interpret all Plan provisions, including its subrogation provisions, and their final effect. Any decision made by the Plan Administrator shall be final and binding.

## COBRA CONTINUATION COVERAGE

### Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse’s plan), even if that plan generally doesn’t accept Late Enrollees.

### What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if a part of your Employer’s Plan) are not considered for continuation under COBRA. **A domestic partner is not a qualified beneficiary.**

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

**Note:** Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee’s hours of employment are reduced;
- The parent – covered Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a “Dependent child.”

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee’s Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Continuation Coverage available?**

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

**Plan Administrator**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60<sup>th</sup> day following the Qualifying Event.

### **How is COBRA Continuation Coverage provided?**

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

### **How long does COBRA Continuation Coverage last?**

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

### **Medicare extension of COBRA Continuation Coverage**

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

### **Disability extension of 18-month period of COBRA Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60<sup>th</sup> day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

### **Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

### **Does COBRA Continuation Coverage ever end earlier than the maximum periods above?**

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

### **How Do I Pay for COBRA Continuation Coverage?**

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

### **Are There Other Coverage Options Besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **Additional Information**

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

**Plan Administrator**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

**COBRA Administrator**  
Employee Benefit Management Services, LLC (EBMS)  
P.O. Box 21367  
Billings, Montana 59104  
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act (PHSA), COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

### **Current Addresses**

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **COBRA CONTINUATION COVERAGE FOR A RETIREES' DEPENDENTS**

**COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.**

### **Introduction**

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to certain Plan Participants when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

### **What is COBRA Continuation Coverage?**

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if a part of your Employer's Plan) are not considered for continuation under COBRA. **A domestic partner is not a Qualified Beneficiary.**

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

**Note:** Medicare entitlement means that you are eligible for and enrolled in Medicare.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parent-covered Retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Continuation Coverage available?**

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

**Plan Administrator:**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60<sup>th</sup> day following the Qualifying Event.

### **How is COBRA Continuation Coverage provided?**

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

### **How long does COBRA Continuation Coverage last?**

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree (or former member), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

### **Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator:**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

### **Does COBRA Continuation Coverage ever end earlier than the maximum periods above?**

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

### **How Do I Pay for COBRA Continuation Coverage?**

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

### **Are There Other Coverage Options Besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **Additional Information**

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

**Plan Administrator:**  
Treasurer and Privacy Officer  
High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

**COBRA Administrator:**  
Employee Benefit Management Services, LLC (EBMS)  
P.O. Box 21367  
Billings, Montana 59104  
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act (PHSA), COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

### **Current Addresses**

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** High Plains Educational Cooperative #611 Employee Health Benefit Plan is the benefit plan of High Plains Educational Cooperative #611, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by High Plains Educational Cooperative #611 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies, or is otherwise removed from the position, High Plains Educational Cooperative #611 shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

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

### DUTIES OF THE PLAN ADMINISTRATOR.

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

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

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

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

The cost of the Plan is funded as follows:

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

**For Retired Employee and Dependent Coverage:** Funding is derived solely from the contributions made by the covered Retired Employees.

The level of any Employee and Retired Employee contributions will be set by the Plan Administrator.

Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employer or withheld from the Employee's pay through payroll deduction.

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

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

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

## **CLERICAL ERROR**

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

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

## **AMENDING AND TERMINATING THE PLAN**

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

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

**STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION  
(THE “PRIVACY STANDARDS”) ISSUED PURSUANT TO THE HEALTH INSURANCE  
PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

**Disclosure of Summary Health Information to the Plan Sponsor**

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

**Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes**

“Protected Health Information” (PHI) means individually identifiable health information, created, or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

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

- (1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- (10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
- (a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

**Treasurer and Privacy Officer**

- (b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- (c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay, and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

**Disclosure of Certain Enrollment Information to the Plan Sponsor**

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

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

**Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

**STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION  
(THE “SECURITY STANDARDS”) ISSUED PURSUANT TO THE HEALTH  
INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

**Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions**

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- (3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
- (4) Report to the Plan any security incident of which it becomes aware.

## **GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

**PLAN NAME:** High Plains Educational Cooperative #611 Employee Health Benefit Plan

**TAX ID NUMBER:** 48-0856876

**PLAN EFFECTIVE DATE:** October 1, 1994

**PLAN YEAR ENDS:** September 30

### **EMPLOYER INFORMATION**

High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

### **PLAN ADMINISTRATOR**

High Plains Educational Cooperative #611  
621 E. Oklahoma  
Ulysses, Kansas 67880  
(620) 356-5577

### **CLAIMS ADMINISTRATOR**

Employee Benefit Management Services, LLC  
P.O. Box 21367  
Billings, Montana 59104  
(406) 245-3575 or (800) 777-3575

**Plan Name:** High Plains Educational Cooperative #611 Employee Health Benefit Plan

**Effective:** October 1, 1994

**Restated:** October 1, 2021

**Legal Compliance:** This Plan is intended to comply with all applicable federal laws and findings of their regulatory authorities and by this provision is automatically amended to be in minimal compliance as necessary.

**Claims Filing Deadline:** If, due to provider error or administrative delay, claims are not filed by the Plan's claim filing deadline, the Plan Administrator may, at his sole discretion and without setting any precedent, accept and process such claims as covered by the Plan, provided such claims are submitted no later than 365 days after the end of the Calendar Year in which services are provided.

I, Christine Mangels, certify that I am the Treasurer  
Name Title

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan as of the restatement date noted above.

Signature: Christine Mangels

Print Name: Christine Mangels

Date: 2/15/22

## APPENDIX A

### NOTICE OF NONDISCRIMINATION – KANSAS

Your health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your Human Resources Department. If you believe that your health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator in the Human Resources Department, Chrissie Mangels, 621 E. Oklahoma, Ulysses, KS 67880, Phone: (620) 356-5577 or by email at: [chrissie@hpec611.net](mailto:chrissie@hpec611.net). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>.

#### **Español (SPANISH)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-620-356-5577**.

#### **Tiếng Việt (VIETNAMESE)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-620-356-5577**.

#### **繁體中文 (CHINESE)**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-620-356-5577**。

#### **DEUTSCH (GERMAN)**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-620-356-5577**.

## 한국어 (KOREAN)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-620-356-5577 번으로 전화해 주십시오.

## LAO/LAOTIAN

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-620-356-5577.

## العربية (ARABIC)

مقر (1-5577-356-620) مقرب لصتا. ناجملا ب كل رفوتت قيوغلا قدعاسملا تامدخ ناف، ةغلا ركذا ثحتت تنك اذا: ةظوحلم) 1-5577-356-620 مكبلو مصلا فتاه:

## TAGALOG (TAGALOG – FILIPINO)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-620-356-5577.

## မြန်မာစာ (BURMESE)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်

စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ရန်ကုန် (1-620-356-5577)

## Français (FRENCH)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-620-356-5577.

## 日本語 (JAPANESE)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1-620-356-5577. まで、お電話にてご連絡ください。

## Русский (RUSSIAN)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-620-356-5577.

## HMOOB (HMONG)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-620-356-5577.

## PERSIAN (FARSI)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

تماس بگیرید. 1-620-356-5577

## KISWAHILI (SWAHILI)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata huduma za lugha, bila malipo.

Piga simu 1-620-356-5577.