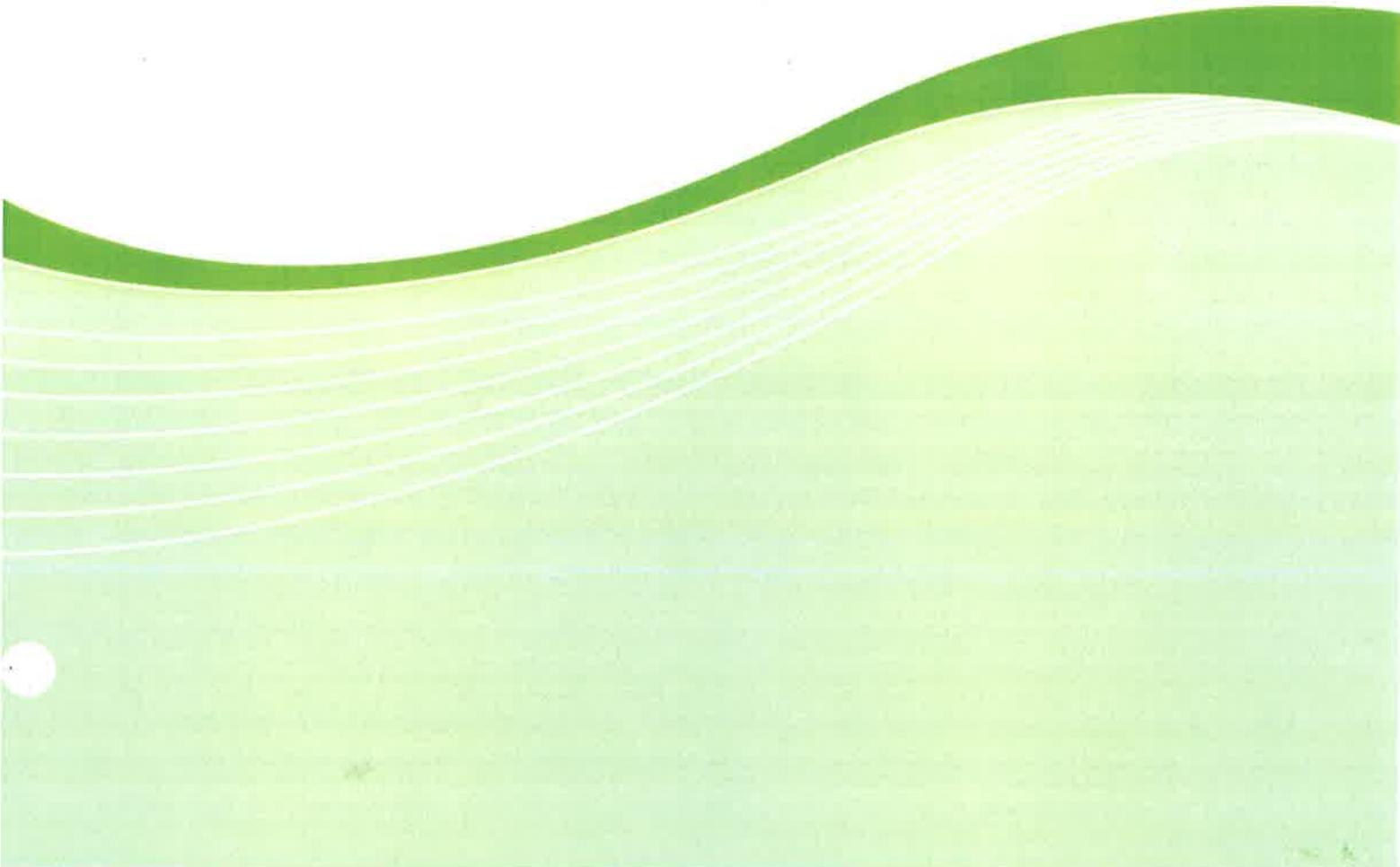




**WCA Group Health
Trust Sawyer County**
Vision Benefit Plan

Group Number: WCA0058
Effective: January 1, 2014



SUMMARY PLAN DESCRIPTION

EMPLOYEE VISION PLAN FOR

**WCA GROUP HEALTH TRUST
SAWYER COUNTY**

GROUP NUMBER: WCA0058

Underwritten By:
WCA Group Health Trust
22 East Mifflin Street Suite 900
Madison, Wisconsin
(866) 404-2700 (toll-free)

Effective Date: January 1, 2014

Online Services from UMR

Accessing Online Services

1. Visit: www.umar.com
2. Select "Members"
3. For members with health or dental coverage: Enter the member ID located on your ID card in the Online Services Access box.
4. Click "Go to my online services." Our Web site will redirect you to your online services home page.
5. When you link to umar.com for the first time, you will need to create a username and password to register for online services. Click the **Need a Username? Register here.** link and follow the prompts to complete your registration.

Claim, Eligibility and Benefit Inquiry

You can view your claims, including copies of explanations of benefits (EOBs), eligibility or benefits information, including a copy of your summary plan description (SPD), any time of the day or night.

Other Insurance and Accident Details

If you have claims pending for updates to other insurance or accident details information, you can make those updates online.



ID Card Ordering

Order duplicate or replacement ID cards quickly and easily.

Member Health Information

UMR provides a wealth of information and services to help you live a healthier life, including tools to help you make the best decisions about health conditions and prescription drugs.

In addition, we provide links to excellent health information sites, articles, and a whole lot more.

(continued on back)



A UnitedHealthcare Company

Provider Network Links

For your convenience, we've set up a link to your provider network. When you click on the link, the network provider's home page is displayed. You can click the link on the home page to search for in-network physicians or medical facilities.

Forms

Our most widely used forms are available online for easy access.

Questions?

If you have any questions or problems with your online services, please contact our technical support team at **1-866-922-8266** between 8 a.m. and 5 p.m. Central time, or reference our online tutorial guides.

If you have questions about a claim or the benefits available to you and your dependents, call us at the number on your ID card.

*UMR provides a
wealth of information
and services to help
you live a healthier life.*



A UnitedHealthcare Company

IMPORTANT MESSAGE

You should report **ANY CHANGE IN ELIGIBILITY** to Your Employer as soon as possible. Changes in eligibility include:

- ◆ Marriage or divorce
- ◆ Death of any Dependent
- ◆ Birth or adoption of a child
- ◆ Dependent child reaching the limiting age
- ◆ Total Disability
- ◆ Retirement
- ◆ Medicare eligibility

For specific details on maintaining coverage under the Plan, refer to **SECTION 3 - ELIGIBILITY**.

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SECTION 1 VISION BENEFITS

PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan for the benefits selected by the Covered Employee, subject to deductibles, coinsurance, maximums and all other terms, provisions, limitations, conditions and exclusions of the Plan. Capitalized words and phrases are defined in Section 2 – Definitions.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

This Plan is designed to cover visual needs, rather than cosmetic materials. No benefits will be payable for the following material options:

- Blended lenses
- Contact lenses (except as noted)
- Low vision
- Cosmetic lenses
- Tinted lenses, except Pink #1 and #2
- Optional cosmetic processes
- The laminating of a lens or lenses
- Oversize lenses
- Photochromatic lenses
- Progressive multifocal lenses
- UV protected lenses
- The coating of the lens or lenses

BILL REVIEW

You should carefully review Your bill for any service. If You find any errors such as:

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received,

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bills, with the errors circled, and the corrected bill to the Claims Administrator. This serves as proof that the provider of service agreed to the corrections. If You are correct, You will receive 50% of the errors in the bill, but not more than \$500 per bill.

NOTE: UMR, Inc. is the Plan's Claims Administrator. UMR, Inc. provides clerical and claim processing services to the Plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the Plan, nor is UMR, Inc. a fiduciary to this Plan.

SCHEDULE OF BENEFITS

VISION BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Individual Deductible per Calendar Year	\$0	\$0	No Deductible	

All Covered Expenses under the Plan are payable at the Plan's Usual, Customary and Reasonable limits.

BILL REVIEW

If You discover a billing error, report it to the Plan. As a reward, You will receive 50% of the error amount, but not more than \$500 paid per bill.

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Exams (including eye refractions)	\$10 copay per visit, then 100%	Limited to one exam per Calendar Year.	1-5
Lenses Single Vision Bifocal Trifocal Lenticular	\$25 copay per visit, then 100%	Limited to once per Calendar Year. This copay is combined for all vision materials (i.e. lenses, frames and contacts). Benefits are not payable if contact lenses have already been paid for during the same Calendar Year.	1-5
Contact Lenses (including maintenance/fitting fees)	\$25 copay per visit, then 100%	Elective Contacts: Limited to \$125 paid per Calendar Year. This copay is combined for all vision materials (i.e. lenses, frames and contacts). Benefits are not payable if glasses have already been paid for during the same Calendar Year.	1-5

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Frames	\$25 copay per visit, then 100% up to a maximum benefit paid of \$150 per Calendar Year.	One set of frames per Calendar Year. This copay is combined for all vision materials (i.e. lenses, frames and contacts).	1-5
Limitations and Exclusions	Not Payable	List of exclusions that apply to all covered expenses. A service that is normally covered may be excluded when provided with an excluded item.	1-6

VISION COVERED EXPENSES

The following services and materials are payable as shown on the Schedule of Benefits when provided by a licensed optometrist, ophthalmologist or dispensing optician.

VISION EXAMS

Vision examinations, including refractions. Limited to one examination per Calendar Year. This includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

MATERIALS

Lenses

When a vision examination indicates that corrective lenses are necessary to maintain Your visual health, the cost of such lenses will be payable as shown on the Schedule of Benefits. Benefits include single vision, bifocal, trifocal and lenticular eyeglass lenses. Benefits will be subject to the frequency limits shown on the Schedule of Benefits. Anti-scratch coatings will be considered a Covered Expense.

Contacts

When a vision examination indicates that corrective lenses are necessary to maintain Your visual health, the cost of such lenses will be payable as shown on the Schedule of Benefits and will be subject to the frequency limit shown on the Schedule of Benefits. Any maintenance fees or fitting fees associated with the purchase of contact lenses will also be considered a Covered Expense.

Contact lenses will only be considered necessary (non cosmetic) if used for one of the following:

1. Following cataract surgery;
2. To correct extreme visual acuity problems to 20/70 in the better eye;
3. Irregular astigmatism;
4. Irregular corneal curvature;
5. Keratoconus.

Frames

The cost of one set of frames per Calendar Year will be payable as shown on the Schedule of Benefits.

MAXIMUM PAYMENT

The amounts shown on the Schedule of Benefits are maximums. The Covered Expense will be the maximum amount shown, or the Expense Incurred, whichever is less.

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. Services or materials connected with:
 - a. orthoptics or vision training procedures,
 - b. ancillary supplies for contact lens,
 - c. aniseikonic lenses,
 - d. certain special no line multifocal or bifocal lenses (blended type) without prior approval,
 - e. two pair of lenses in lieu of bifocals,
 - f. tinted lenses (except pink #1 & #2),
 - g. plano (non-prescription) lenses,
 - h. sunglasses, plain or prescription,
 - i. anti-reflective coating; other coatings, except as specifically stated; or laminated lenses,
 - j. oversize blanks,
 - k. photochromatic (light sensitive) lenses;
2. Medical or surgical treatment of the eye;
3. Any Injury or Sickness arising from or sustained in the course of any occupation for employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;
4. Any procedures or materials required as a condition of employment, including but not limited to, industrial safety glasses;
5. Charges for services or supplies furnished prior to the date the Covered Person becomes covered for this benefit;
6. Charges made after the Covered Person's termination date;
7. Services or supplies that are paid under any other provisions of this Plan;
8. Drugs; or
9. Treatment in connection with or as a result of any service or supply that is not a Covered Expense.

SECTION 2 DEFINITIONS

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DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in this Plan. Defined words are capitalized throughout the Plan.

Actively at Work

An Employee is Actively at Work if he or she is employed by the County and meets the minimum requirements set by the County for eligibility under the Plan. An Employee is not considered Actively at Work if he or she has been laid off or is absent from work for reasons other than those which entitle the Employee to leave under family and medical leave laws or a Health Factor, and such layoff or absence from work is for such a period of time that the employee is no longer eligible for the benefits of this Plan pursuant to the rules or policies established by the County or the terms of any applicable collective bargaining agreement.

Amendment

A written document that changes the provisions of the Plan. It must be duly authorized and signed by the Plan Administrator.

Business Associate

A Business Associate is a person who provides, other than in the capacity of a Plan Employee, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Plan where the provision of the service involves the disclosure of individually identifiable health information from the Plan or from another Business Associate to the person.

Calendar Year

A 12 month period of time that starts on January 1 and ends on December 31.

Claims Administrator

The person or entity employed by the Plan Administrator to provide administrative services in connection with the operation of the Plan and any other functions, including the processing of claims. If no Claims Administrator is employed by the Plan Administrator, Claims Administrator will mean the Plan Administrator.

County

The County or other governmental unit, identified on the cover page, which employs the Covered Employee.

Covered Dependent

An Employee's eligible Dependent who is properly enrolled in the Plan.

Covered Employee

An Employee who is eligible and properly enrolled in the Plan.

Definitions – continued

Covered Expense

Expense Incurred by You or Your Covered Dependent for services or supplies provided by a Qualified Practitioner.

Covered Person

A Covered Employee or Covered Dependent.

Dependent

1. A covered Employee's lawful spouse, as defined in the State where You reside, provided that:

- a. the spouse is not legally separated from the Employee, and
- b. the Employee is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;

2. A covered Employee's married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age. The limiting age for each Dependent child is shown below:

A married or unmarried Dependent child may be covered until the end of the Calendar Year in which such child reaches age 26.

After age 26, an unmarried Dependent child may be covered until the end of the month in which such child reaches age 27, provided such child is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a dependent under the this Plan).

Coverage may be extended (beyond age 27) for a Dependent child if **all** of the following requirements are met:

- a. The Dependent child is a full-time student, regardless of age, and
- b. The Dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a Dependent under the Employee), and
- c. The Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. The Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

1. the date the child's coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

Definition of Dependent - continued

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

3. A Covered Employee's grandchild, as long as the Employee's Covered Dependent child, who is the parent of the grandchild, is not yet 18 years old.

A Covered Dependent child who attains a limiting age while covered under this Plan will remain eligible for benefits if the Plan Administrator determines that all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;
2. The child is incapable of self-sustaining employment because of mental retardation or physical handicap;
3. The child is chiefly dependent on the Covered Employee for support and maintenance; and
4. The child was never married.

That child that child will remain an eligible Dependent of a Covered Employee or may be enrolled as the Dependent of a new Employee. If the child has not continuously satisfied all of the conditions above since reaching a limiting age, the child will not be eligible for coverage under the Plan.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof may not be requested more often than annually after two years from the date the first proof was provided. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

In any event, no person may be covered as both an Employee and a Dependent at the same time. If both parents are eligible for coverage under this Plan, only one may enroll for Dependent coverage.

Right To Check Dependent Eligibility

The Plan reserves the right to check the eligibility status of a Dependent at any time during the year. You and Your Dependent have an obligation to notify the Plan when the Dependent's eligibility status changes during the year. Please notify Your Employer of any status changes.

Effective Date

The effective date stated on the front of this Plan.

Employee

You, when You are regularly employed by the County.

Employer

Sawyer County who employs the Covered Employee.

Definitions – continued

Expense Incurred

The amount charged for services and supplies needed to treat the Injury or Sickness. The Expense Incurred date is the date a supply or service is provided.

Family

A Covered Employee and the Covered Employee's Covered Dependents.

Family Member

Your lawful spouse, child, parent, grandparent, brother or sister, or any person related in the same way to Your covered Dependent.

Health Factor

The health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including whether an individual is a victim of domestic violence or engages in activities such as motorcycling, horseback riding, snowmobiling or similar activities, or disability of any Employee or any Dependent of any Employee.

Injury

Physical damage to Your body caused by an external force and due, directly and independently of all other causes, to an Accident.

Late Applicant

An Employee or an Employee's eligible Dependent who enrolls or is enrolled for coverage more than 31 days (60 days for newborns and adopted children) after his or her initial eligibility date.

Lifetime

When used in reference to benefit maximums and limitations, the entire time You are covered under this Plan, whether or not Your coverage is continuous. In no circumstances does Lifetime mean Your life span.

Medicare

Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

Named Fiduciary

WCA Group Health Trust, which has the authority to control and manage the operation of the Plan.

Pediatric Services

Services provided to a Covered Person under the age of 19.

Definitions - continued

Plan

The Plan of vision expense benefits described in this document and including any schedules, attachments and Amendments to this document. Prior, current and successive Plans will be considered one plan and not separate and distinct plans. This Summary Plan Description provides a description of the Plan.

Plan Administrator or Trust

WCA Group Health Trust

Plan Sponsor

The Plan Sponsor of the Plan is WCA Group Health Trust

Post-Service Claim

Any claim that is not a pre-service claim.

Pre-Service Claim

Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the Plan for the medical care.

Protected Health Information

Protected Health Information means individually identifiable health information that is: transmitted or maintained in any form or medium; is created or received by a health care provider, the Plan an employee or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual.

Qualified Practitioner

A practitioner, licensed to provide vision services, who is providing services within the scope of that license, except a practitioner who resides in Your home or is a family member.

Sickness

1. A disease or disturbance in function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of Your body.
2. Muscle tiredness or soreness resulting from overexertion in a physical activity.
3. Pregnancy.

Definitions - continued

Total Disability or Totally Disabled

Your inability due to Sickness or Injury to perform the substantial full-time duties of any job with the County. You also cannot be working for wage or profit for anyone, including yourself.

For Dependents, it means the inability due to Sickness or Injury to carry on all of the normal activities of a healthy person of the same age and sex.

Urgent Care

Any care that in the opinion of Your Qualified Practitioner is an urgent care situation. Any care that the use of non-urgent care time frames would put Your life, health or ability to regain maximum function at risk.

Usual, Customary and Reasonable (UCR)

The lesser of:

1. The fee most often charged by the provider; or
2. The maximum allowable fee as determined by the Plan Administrator by comparing similar services or procedures to a national data base adjusted to the locality where the services or procedures were performed.

You and Your

You as the Covered Employee. Any of Your Dependents, unless otherwise indicated.

SECTION 3 ELIGIBILITY

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to Employees hired on or after the effective date of this Plan. The Dependent Coverage section applies to Dependents that are added on or after the effective date of this Plan.

Employees who were covered under any plan that this Plan replaces will be covered on the effective date of this Plan. Coverage will include Dependents of such an Employee. You must have met the eligibility requirements of the Plan.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the Plan if the following conditions are met:

1. You are an Employee who meets the eligibility requirements of the County; and
2. You satisfy an eligibility period of 30 consecutive days of regular employment with the County.

You are eligible to be covered on the first day of the month after You complete the eligibility period. This is Your eligibility date.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms furnished and accepted by the Plan Administrator. Each Employee's effective date of coverage is determined as follows:

1. If Your completed enrollment forms are received by the Plan Administrator within 31 days of Your eligibility date, Your coverage is effective on Your eligibility date.
2. If Your completed forms are received by the Plan Administrator more than 31 days after Your eligibility date, this is considered **Late Enrollment**. Your coverage will be effective on the first of the month following the date Your completed enrollment forms are received by the Plan Administrator.

Employee coverage will begin at 12:01 AM, Standard Time, on Your effective date. You must actually begin active work with the County before coverage will be effective under the Plan.

DEPENDENT ELIGIBILITY

Each Dependent is eligible for coverage on the later of:

1. The date the Employee is eligible for coverage, if the Employee has Dependents on that date;
2. The date of the Covered Employee's marriage for any Dependents acquired on that date;
3. The date of birth of the Covered Person's natural born child;
4. The date a court order places a child in the Employee's home. The child must be under the Employee's legal guardianship;
5. The date a child is legally adopted; or

Dependent Eligibility - continued

6. The date a valid court order is issued which, by federal law or Plan provision, requires the Plan to provide coverage.

Dependents of an Employee may be covered only if the Employee is also covered.

If both the Employee and a Dependent are eligible for Employee coverage under this Plan, each Covered Expense is payable only once and each Covered Person is covered only once.

DEPENDENT EFFECTIVE DATE OF COVERAGE

Each Dependent's effective date of coverage is determined as follows:

1. If a Dependent's completed enrollment forms are received by the Plan Administrator within 31 days of the Dependent's eligibility date that Dependent is covered on his or her eligibility date.
2. An eligible newborn of a Covered Person is covered for 60 continuous days from the moment of birth. If the newborn's enrollment forms are received by the Plan Administrator within 60 days of the date of birth, then the newborn will be a Covered Dependent effective the moment of birth.
3. If the newborn's enrollment forms are received by the Plan Administrator more than 60 days and within one year after the date of birth and the Covered Employee makes all past due premium payments with interest at the rate of 5 ½% per year, then the newborn will be a Covered Dependent effective the moment of birth.
4. If You marry after Your coverage is effective, You should apply for Family Coverage within 31 days of Your marriage. If You do, Your Family Coverage becomes effective on the date of the marriage.
5. If a Dependent's completed enrollment forms are received by the Plan Administrator more than 31 days after the Dependent's eligibility date, this is considered **late enrollment**. Coverage for that Dependent will be effective on the first day of the month following the date the Dependent's completed enrollment form is received by the Plan Administrator.

Dependent coverage will begin at 12:01 AM, Standard Time, on the Dependent's effective date of coverage under the Plan.

RETIREE COVERAGE

If You are at least age 55 (52 for the Sheriff's Department) and You have at least 15 years of service with the County, You may be eligible for Retiree Coverage for Yourself and any eligible Dependents. Retiree Coverage will end on the date You become Medicare-eligible, whether You elect Medicare or not. At that time, coverage will also end for any Dependents of the Retiree. The Retiree must pay the full cost of Plan contributions.

When Retiree Coverage ends, COBRA Continuation will be offered to any eligible person.

SPECIAL ENROLLMENT RIGHTS

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Applicant provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

Loss of Other Coverage

If You declined coverage under this Plan in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other group Plan or COBRA:

1. Ends due to Your exhaustion of the maximum COBRA period;
2. Ends due to Your loss of eligibility, for any reason;
3. Ends Employer contributions towards the cost of the other coverage;
4. The amount of premiums Your spouse is required to pay, for covered under the spouse's plan, goes up by at least 25% of the family plan rate; or
5. The amount of contribution You are required to pay for coverage under this Plan goes down by at least 25% of the family plan rate.

Then a special enrollment event has occurred. At that time, an Employee or Dependent may be enrolled in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependents may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;
2. When a Dependent has a loss of coverage, only that Dependent and the Employee may enroll. The Employee does not have to have had a loss of coverage at that time to enroll. Other Dependents that did not have a loss of coverage will be considered Late Applicants.

You must enroll in this Plan within 30 days of the date of a loss of other coverage to be a timely entrant to the Plan. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this Plan will not be effective until such proof is provided. Coverage under this Plan will be effective on the day coverage under the other group plan ends.

If You apply more than 31 days after the date the other coverage ends, You will be Late Applicants under this Plan.

Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage may also be enrolled at this time. Any other Dependents that were not previously covered under the Plan will be considered Late Applicants.

You must enroll in this Plan within 31 days of the date of marriage to be a timely entrant to the Plan. Coverage under the Plan will be effective on the day of Your marriage. If You apply more than 31 days after the date of Your marriage, it will be considered late enrollment under this Plan.

Special Enrollment Rights - continued

Birth, Adoption or Placement for Adoption

If You experience the birth of a Dependent child, or the adoption or placement for adoption of a Dependent child, a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse and the newborn or adopted child may also be enrolled at this time. Any other Dependents that were not covered under the Plan will be considered Late Applicants.

You must enroll in this Plan within 31 days (60 days for a newborn child or an adopted child) of the date of birth, adoption or placement to be a timely entrant to the Plan. Coverage under the Plan will be effective on the date of such an event. If You apply more than 31 days (60 days for a newborn child or an adopted child) after the date of such an event, it will be considered Late Enrollment under this Plan.

MEDICAID/STATE CHILD HEALTH PLAN

If You and/or Your Dependents were covered under a Medicaid plan or State child health plan and Your coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this Plan within 60 days after the date of termination of such coverage. Coverage under this Plan will be effective on the date the other coverage ends. If You apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, You will be considered a Late Applicant under this Plan.

Premium Assistance

Current Employees and their eligible Dependents may be eligible for a special enrollment event if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or State child health plan, for premium assistance with respect to coverage under this Plan. You must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance. If You apply for coverage more than 60 days after this date, You will be considered a late Applicant under the Plan.

SPOUSAL TRANSFER PROVISION

If both spouses are Employees and each has taken single coverage under this Plan, this Plan permits Your spouse to take coverage as Your Dependent at any time.

In addition, if both spouses are Employees and eligible for coverage under this Plan and Your spouse previously waived coverage as an Employee in favor of coverage as Your Dependent, this Plan permits Your spouse to take coverage as an Employee under the Plan and to enroll Your and any other eligible Dependents as Dependents of Your spouse when:

1. You and Your spouse decide to transfer coverage under the Plan from one spouse to the other;
2. Your spouse decides to take coverage as an Employee for any reason; or
3. You terminate Your coverage under the Plan for any reason.

Your spouse must elect coverage under this Plan within 30 days of the date Your coverage ends to be a timely enrollment. Your spouse's coverage under this Plan will be effective on the day Your coverage ends.

If Your spouse applies more than 30 days after the date Your coverage ends, You will be Late Applicants under the Plan.

Vision - Effective 1/1/14

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all Employees and Dependents. Any change in coverage will be effective on the date of change for all Employees and Dependents.

REINSTATEMENT OF COVERAGE

If You return to work within six months of a termination due to layoff or approved leave of absence, Your coverage will be effective on the day You return to work. The eligibility period will be waived with respect to the reinstatement of Your coverage. The pre-existing condition exclusion will be waived to the extent it was already satisfied.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. For any benefit, the date the benefit is removed from the Plan;
3. The end of the period for which any required Employee or County contribution was due and not paid;
4. The date You enter the full-time military, naval or air service of any country;
5. The last day of the month following the month in which You cease to be eligible according to the eligibility requirements of the County;
6. For all Employees, the last day of the month following the month in which You receive Your final payroll check from the County;
7. For all Retired Employees, the last day of the month following the month You receive Your final payroll check from the County, unless You are eligible for, and elect, Retiree Coverage;
8. For a Dependent, the date the Employee's coverage terminates;
9. For a Dependent, the date that Dependent no longer meets this Plan's definition of a Dependent;
10. For a Dependent, the date the Dependent enters the full-time military, naval or air service of any country;
11. For an Employee's spouse, the date of entry of a judgment of divorce or annulment of the marriage;
12. The date You request termination of coverage to be effective for Yourself and/or Your Dependents; or
13. The date You die. (If the Covered Employee dies, such Employee's Covered Dependents (spouse and children) may remain covered under this Plan until the last day of the month in which the Covered Employee died.)

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

The Plan cannot terminate Your coverage due to age or Medicare status. An active Employee that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or
2. End coverage under this Plan, in which case Medicare would be the only coverage available to You.

An active Employee's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.

Contact Your Employer for further information.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to Employers with 50 or more Employees. It requires that coverage under this Plan be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the Employee as it would have been had FMLA leave not been taken.

If this Plan is established while You are on FMLA, Your coverage will be effective on the same date it would have been had You not taken leave. If the Plan is amended while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken leave.

EMPLOYEE ELIGIBILITY

An Employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The Employee has been employed with the Employer for a total of at least 12 months;
2. The Employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
3. The Employee is employed at a worksite that employs at least 50 Employees.

TYPES OF LEAVE

Coverage under this Plan can be continued during a period of FMLA leave. The Employee must continue to pay the Employee portion of the Plan contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the Employer, for:

1. The birth of the Employee's child;
2. The placement of a child with the Employee for adoption. The placement of a child with the Employee for foster care;
3. The Employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;
4. The Employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or
5. Any qualifying necessity that results from the Employee's spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the Employer, to care for a member of the armed forces that is the Employee's spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

FMLA - continued

Maximum Leave Period

The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the Employee and the Employee's spouse are both employed by the Employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;
2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or
3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period

If the Employee decides not to return to work, coverage under the Plan may end at that time.

If the Plan contribution is not paid within 30 days of its due date, coverage under the Plan may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an Employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions

The Employer has the right to recover the portion of Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave. If the Employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work. Reinstatement will apply whether coverage under the Plan was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived.

DEFINITIONS

For this provision only, the following terms are defined as shown below:

Serious Health Condition is any Sickness, Injury, impairment or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;

FMLA - continued

2. Continuing treatment by a Qualified Practitioner, including any period of incapacity:
 - a. for more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or a Qualified Practitioner is consulted at least once and a continuing treatment program is provided;
 - b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
 - c. due to a chronic condition (i.e. a condition which requires periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
 - d. which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective;
 - e. to receive multiple treatments from a Qualified Practitioner for restorative surgery due to Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is Your lawful husband or wife.

Son or Daughter is Your natural blood related child, adopted child, step-child, foster child, a child placed in Your legal custody or a child for which You are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or
2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is Your natural blood related parent or someone who has acted as Your parent in place of Your natural blood related parent.

NOTE: To the extent that State or local law requires an Employer to provide greater leave rights than those stated above, this Plan will provide that greater right. For complete information regarding Your rights under the FMLA, contact Your Employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that the Employer provide a cumulative total of five years and in certain instances more than five years, of military leave during an Employee's employment with the Employer.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that the Employer continue to provide coverage under this Plan, during a military leave that is covered by the Act, for You and Your Dependents. Coverage provided must be identical to coverage provided under the Employer's Plan to similarly situated, active Employees and Dependents. This means that if the coverage for similarly situated, active Employees and Dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the Employee contribution required for active Employees;
2. For military leaves of 31 days or more, up to 102% of the full contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages. Short and long term disability and life benefits are not subject to this provision.

For an Employer subject to COBRA, continued coverage provided under this Act will reduce any continuation provided under COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Employer following completion of Your military leave. Employees must return to employment within:
 - a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
 - b. 14 days of completing military service, for leaves of 31 to 180 days,
 - c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date Your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day of completing Your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing Your military service, for leaves of 31 to 180 days;
3. 90 days of completing Your military service, for leaves of more than 180 days.

USERRA - continued

If, due to a Sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived as if You had been continually covered under the Plan from Your original effective date.

This waiver of limitations does not provide coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veterans Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to Employers that have 20 or more employees. The law requires these Employers to offer covered individuals continuation coverage (COBRA) under the Plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The Employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active Employees under the Plan. This means that when coverage is changed for similar active Employees it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work; or
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part.

Spouse Rights to COBRA

The spouse of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;
3. The death of the Employee;
4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The Employee becoming entitled to Medicare.

Dependent Child Rights to COBRA

The Dependent child of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;
3. The death of the Employee;
4. The end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

COBRA – continued

5. The Employee becoming entitled to Medicare; or
6. The child ceasing to be considered a Dependent child as defined in this Plan.

Electing COBRA

Each person covered by this Plan has an independent right to elect COBRA for himself or herself. A Covered Employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the Employee's Dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the Employee during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, You have a right to elect COBRA. You also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the Employer files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, You must inform the Plan Administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. You must also inform the Plan Administrator within 60 days of a child no longer meeting the Plan's definition of Dependent. The Employer must notify the Plan Administrator of: the Employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The Employer must also notify the Plan Administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the Plan Administrator will notify You that You have the right to elect COBRA. If the Employer and Plan Administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law You must elect COBRA within 60 days from the later of: the date You would lose coverage or cost would increase due to the qualifying event; or the date notice of Your right to COBRA and the election form are sent.

The Plan Administrator must provide You with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If You elect COBRA within the 60 day period, COBRA will be effective on the date that You would lose coverage. If You do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the Plan will terminate.

COBRA – continued

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The Plan may add a 2% administration charge to that cost. The Plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the Plan Administrator.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the Employer maintain COBRA for up to:

1. 18 months, if due to the Employee's termination of employment. Termination must be for reasons other than gross misconduct on the Employee's part;
2. 18 months, if due to the Employee's reduction in work hours;
3. 36 months, if due to the death of the Employee;
4. 36 months, if due to the end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. 36 months, if due to the Employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the Employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;
6. 36 months, if due to Your ceasing to be a Dependent child as defined in the Plan; or
7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered Dependent may elect COBRA for an additional 36 months from that date.

If You or a Dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if You or a Dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the Plan Administrator within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, You will not be eligible for the extended period. If it is determined that You are no longer disabled, You must notify the Plan Administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the Employee's death; the Employee's divorce; a child no longer meeting the definition of Dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

COBRA – continued

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the Plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The Employer no longer provides a group benefit plan to any of its Employees;
2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;
3. You obtain another group plan after the date you elect COBRA;
4. You become entitled to Medicare after the date you elect COBRA;
5. There has been a final determination that You are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Additional Election Period due to The Trade Act of 2002

If You did not elect COBRA during the election period described above, another 60 day period may be presented for You to elect COBRA. If Your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and You are determined to be TAA eligible during the six month period following Your loss of coverage, You will have an additional period in which to elect COBRA. This election period will begin the first of the month in which You become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following Your loss of coverage due to a TAA event.

If *you* elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which *you* became TAA eligible. COBRA will not be provided for the period of time between *your* loss of coverage and the first of the month in which *you* became TAA eligible. If *you* do not elect COBRA within this period, COBRA will not be available again.

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 72.5% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If You have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact.

COBRA – continued

Procedures for Providing Notice to the Plan

In order to maintain Your rights under COBRA, You are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if You provide written notice to the Plan Administrator that includes:

1. The Employee's name and participant number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The Plan Administrator will answer any questions You may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to Your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect Your rights under COBRA, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status; address; or other insurance coverage. When providing any notice to the Plan, a copy should be maintained for Your own records.

SECTION 4 GENERAL PLAN INFORMATION

COORDINATION OF BENEFITS

Benefits Subject to This Provision

Benefits described in this Plan are coordinated with benefits provided by other plans which also cover You. This is to prevent the problem of over insurance and a resulting increase in the cost of coverage. This coordination of benefits provision applies whether or not You file a claim under any other plan You may be covered under.

Effect on Benefits

Benefits will be reduced under certain circumstances when You are covered both under this Plan, as described, and any other plan, as defined below, which provides similar benefits. Total reimbursement from all plans will not exceed 100% of the total Covered Expenses under this Plan.

If the total of the benefits paid by the primary plan and by this Plan is less than the total allowable expenses for the claim, this Plan will use Your available benefit credit to reimburse You for up to 100% of the total allowable expenses.

Definitions

For this Coordination of Benefits provision only, a plan is any coverage which covers medical, dental or vision expenses and provides benefits or services by: :

1. Group or franchise insurance coverage, whether insured or self-funded;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group type contracts not available to the general public obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket or in something else.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Covered Expense. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the Usual, Customary and Reasonable value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Coordination of Benefits - continued

Order of Benefit Determination

A plan will be considered the primary plan and pay benefits first if.

1. The plan has no coordination of benefits provision.
2. The plan covers the person as an Employee.
3. When a Dependent child is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering a parent for the longest period of time will pay benefits first. If a plan other than this Plan does not include a provision similar to this one, then this provision will be ignored in order to coordinate benefits with the other plan. If a plan other than this Plan does not use the birthday rule and uses the gender rule instead, then the gender rule will be followed.
4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
 - a. the plan of a parent who has primary physical placement will be primary,
 - b. the plan of a step-parent that has primary physical placement will pay benefits next,
 - c. the plan of a parent who does not have primary physical placement will pay benefits next, and
 - d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

If one parent has been assigned financial responsibility for the medical expenses of the child, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:
 - a. the plan of a parent who has primary physical placement will pay the benefits first,
 - b. the plan of a parent who does not have primary physical placement will pay benefits next,
 - c. the plan of a grandparent whose child has primary physical placement will pay benefits next,
 - d. the plan of a grandparent whose child does not have primary physical placement will pay benefits next.

If the primary plan is not established by the above rules, the plan that has covered the grandparent or parent for the longest period will be primary.

Subject to the order of benefit determination stated above, if both grandparents in a household are providing coverage for a grandchild, the plan of the grandparent whose birthday (month and day) occurs first in the Calendar Year will pay before the plan of the other grandparent. If both grandparents in a household have the same birthday, the plan covering a grandparent for the longest period of time will pay benefits first.

Coordination of Benefits - continued

7. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee. There are two exceptions to this: a) If a plan other than this Plan does not include a provision similar to this one and, if as a result, the plans do not agree on the order of benefits, this rule will be ignored, and b) If a Dependent is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule. (**NOTE:** If a Retiree is also covered under his or her spouse's plan and that spouse is actively at work, this Plan is primary for the Retiree.)
8. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this Plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

If a service is covered under a medical plan and a dental plan, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare

In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan are subject to the allowable limiting charges, as set by Medicare, and will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this Plan, You agree to all of the following conditions. The payment of any claims by the Plan is an advancement of Plan assets. The Plan has first priority to receive repayment of those Plan assets out of any amount You recover. The Plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before You receive payment from that party. The Plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The Plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not You are made whole.

The Plan will not pay attorney fees without the express written consent of the Plan Administrator. The Plan will not pay any costs associated with any claim or lawsuit without the express written consent of the Plan Administrator.

If You are deceased, the rights and provisions of this section will apply equally to Your estate. If You are legally incapacitated the rights and provisions of this section will apply equally to Your legal guardian.

In consideration of the coverage provided by this Plan, when You file a claim You agree to all of the following conditions. You will sign any documents that the Plan considers necessary to enforce its recovery rights. You will do whatever is necessary to enable the Plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the Plan any rights You have for expenses the Plan paid on Your behalf. You will hold any settlement funds in trust, either in a separate bank account in Your name or in Your attorney's trust account, until all Plan assets are fully repaid or the Plan agrees to disbursement of the funds in writing, if You receive payment from any liable or responsible party and the Plan alleges that some or all of those funds are due and owed to the Plan. You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the Plan. It also includes any medical, dental or loss of time expense that may be payable by the Plan in the future.
2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; You or Your Covered Dependent's own uninsured motorist insurance or under-insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the Plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of Your benefits under this Plan.

Right of Subrogation

If, after payments have been made under this Plan, You have a right to recover damages from a responsible or liable party, the Plan shall be subrogated to that right to recover. The Plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the Plan.

Recovery Rights - continued

Right of Reimbursement

If benefits are paid under this Plan and You recover from a responsible or liable party by settlement, judgment or otherwise, the Plan has a right to recover from You. Recovery will be in an amount equal to the amount of Plan assets paid on Your behalf. The Plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of Plan assets that are paid or payable for any health care expenses under the Plan.

Excess Coverage Provision

Benefits are not payable for an Injury or Sickness if there is any responsible or liable party providing coverage for health care expenses You incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the Plan may make payments on Your behalf for Covered Expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the Plan and will be considered an advancement of Plan assets to You.

This Plan does not provide benefits or may reduce benefits for any present or future Covered Expenses that You have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the Plan.

Workers' Compensation

This Plan excludes coverage for any Injury or Sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the Plan and You receive Workers' Compensation for the same incident, the Plan has the right to recover. That right is described in this section. The Plan reserves its right to exercise its recovery rights against You even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the Injury or Sickness was sustained in the course of or resulted from Your employment;
3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by You or the Workers' Compensation carrier; or
4. The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

GENERAL PROVISIONS

The following provisions are to protect Your legal rights and the legal rights of the Plan.

ALTERNATE RECIPIENTS

If a court order requires a Covered Person to provide health care coverage for a Dependent child, coverage must be provided to the child. Coverage may not be subject to Plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of Dependents are also waived for that child. If a Covered Person does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an Employee under the Plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the Plan. They must be provided with a copy of the Plan's Summary Plan Description (SPD). Any payments made by the Plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

A court order will not entitle the child to any benefits or coverage not already offered by the Plan.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan's benefits may be amended by the Employer at any time. The Plan may be terminated by the Employer at any time. Any changes to the Plan will be communicated immediately by the Employer to the persons covered under the Plan.

If the Plan is terminated, the rights of the Covered Persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. Plan assets will be allocated to the exclusive benefit of the Covered Persons. Any taxes and expenses of the Plan may be paid from the Plan assets.

ASSIGNMENT

Any assignment will only be applied to the extent that the provider of services will refund any erroneous payments. The Plan Administrator does not guarantee the legal validity or effect of any assignment.

CLERICAL ERROR

A clerical error by the County, the Plan Administrator or the Claims Administrator will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

CONFORMITY WITH APPLICABLE LAWS

If any provision of this Plan is contrary to any applicable law, that provision is amended to conform with such law and the rest of the Plan remains in effect.

General Provisions – continued

CONTRIBUTIONS TO THE PLAN

The Plan is funded by contributions from the Employer and Covered Employees.

The Employer determines the amount of the Employee contribution, if any, and reserves the right to adjust or modify such contributions. All Employee contributions are on a non-discriminatory basis.

COOPERATION

You must cooperate with the Plan Administrator, Claims Administrator, and or any person designated by the Plan Administrator in connection with this Plan.

FAILURE TO ENFORCE PLAN PROVISIONS

No failure to enforce any provision of the Plan will affect the right, thereafter, to enforce such provision or affect the right to enforce any other provisions of the Plan.

FREE CHOICE OF PROVIDER

The Covered Person has a free choice of any legally licensed provider. The Plan will not interfere with the provider/patient relationship.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

This Plan is not financed or administered by an insurance company and benefits are not guaranteed by a contract of insurance.

If You have any questions about Your rights under the Health Insurance Portability and Accountability Act of 1996, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 2000 Constitution Avenue, N.W., Washington D.C. 20210.

LEGAL ACTIONS

You cannot bring an action to compel payment under the Plan until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the Plan has denied full payment of Your claim, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

PAYMENT OF CLAIMS

Any payment made in good faith will fully discharge the Plan to the extent of such payment. If benefit payments have been made under any other plan which should have been made under this Plan, the Plan Administrator may reimburse such plan. Any payments made in good faith will fully discharge the Plan's obligations to You to the extent of such payment.

Benefits will be paid directly to the provider of services, unless You direct otherwise in writing at the time proof of loss is filed.

Vision - Effective 1/1/14

General Provisions - continued

Benefits payable on behalf of You or Your Covered Dependent, upon death, will be paid at the Plan Administrator's option to: Your estate; Your spouse; Your Dependent children; Your parents; or Your brothers and sisters.

PHYSICAL EXAMINATION

The Plan Administrator, at its own expense, has the right to have You examined as often as it deems reasonably necessary while a claim is pending.

PRIVACY OF PROTECTED HEALTH INFORMATION

1. Plan Sponsor's Certification of Compliance

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Plan Sponsor

- a. The Plan and any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of Wisconsin law and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Such disclosure will include disclosure for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in the Plan's Notice of Privacy Practices. Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.
- b. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.
- c. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

3. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information

- a. The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.
- b. The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' Protected Health Information.
- c. The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Privacy of Protected Health Information - continued

- d. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
- e. The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524 and any applicable Wisconsin law.
- f. The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526 and any applicable Wisconsin law.
- g. The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528 and any applicable Wisconsin law.
- h. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E ("Privacy of Individually Identifiable Health Information").
- i. The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium, received from the Plan or any Business Associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information that cannot feasibly be return or destroyed to those purposes that make the return or destruction of the information feasible.
- j. The Plan Sponsor will ensure that the required adequate separation, described in detail in paragraph 4, below, is established and maintained.

4. Adequate Separation Between the Plan Sponsor and the Plan

- a. The following persons under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a Business Associate servicing the Plan:

Employees of Wisconsin Counties Association who hold the positions of Director of Insurance Services, Director of Administration and Finance, Insurance Services Administrator, Operations Manager, Executive Administrative Assistant, Administrative Assistant.

All employees of all entities with whom the Plan has entered into Business Associate Agreements to the extent those employees perform tasks for or on behalf of the Plan and/or the Plan Sponsor.

Privacy of Protected Health Information – continued

This list includes every employee or class or employees or other persons under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The employees or other persons above shall also be given access to Plan Participants' Protected Health Information for the purpose of rendering final claim appeal determinations.

- b. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.
- c. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

5. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

- a. The Plan may disclose Summary Health Information (SHI) to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information (SHI) for the purpose of:
 - 1. Obtaining premium bids for the health coverage offered under the Plan; or
 - 2. Modifying, amending or terminating the Plan.

Summary Health Information (SHI) includes aggregated claims history, claims expenses or types of claims experienced by enrollees in the Plan. Although this information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the SHI as belonging to a particular participant.

- b. The Plan may disclose enrollment and disenrollment information to the Plan Sponsor.

PROOF OF LOSS

You must provide the Plan with written proof of Your claim. Proof should be provided as soon as reasonably possible. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless You were legally incapacitated during the period, any claim received by the Plan more than 15 months after the date the claim was incurred will not be covered under the Plan.

Proof of Loss Provision - continued

If the Plan is terminated, written proof of any claims incurred prior to the termination must be given to the Plan within six months of its termination. Any claim received by the Plan more than six months after it is terminated will not be covered under the Plan.

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind and any attempt to accomplish these will be void. If the Plan Administrator finds that such an attempt has been made, the Plan Administrator, at its sole discretion, may terminate the interest of the Covered Person in the payments and apply the amount of the payment to or for the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan to the extent of the payment.

REPRESENTATIONS

All representations by a Covered Person are material and relied upon in providing coverage under the Plan.

RIGHT TO NECESSARY INFORMATION

The Claims Administrator has the right to decide which facts it needs to apply and coordinate these provisions with other plans. It may get needed facts from or give them to any other organization or person without consent of the insured, but only as needed to apply these provisions. Medical records remain confidential as provided by state law. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

SECURITY

The WCA Group Health Trust, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Trust certifies to the Plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;
2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Employer under this provision;
3. Report to the Plan any security incident that the Trust becomes aware of; and
4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

TERMINATION OF THE PLAN

If the Plan is terminated, the rights of the Covered Persons to benefits are limited to claims incurred and payable by the Plan before the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of Covered Persons, except that any taxes and administration expenses may be paid from the Plan assets.

General Provisions – continued

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, Your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the Plan will notify You of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the Plan will give its decision on the claim. If You fail to provide the information requested by the Plan, the Plan will provide You with its decision on the claim within 48 hours of the end of the period that You were given to provide the information.

If You fail to follow the Plan procedure for a Pre-Service Claim, the Plan will notify You within 24 hours of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for You to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a Plan Amendment. This will not apply if the benefit is being stopped due to the termination of the Plan.

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, Your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-Urgent Care claim. The Plan may extend this period by 15 days if You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If You fail to follow the Plan procedure for a non-Urgent Care Pre-Service Claim, the Plan will notify You within five days of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

CLAIM APPEAL PROCEDURE

A two-level appeal process is available under this Plan, followed by the Federal External Review Program. The first level of appeal is to the Claims Administrator (UMR). If You disagree with the result of the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust).

FIRST LEVEL OF APPEAL

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the Claims Administrator, for a full and fair review of the claim by the Plan;
2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of Your appeal.

A request for a review must be filed with the Claims Administrator within 180 days after receipt of the claim denial. If Your request for review is not received within 180 days, Your right to appeal the claim denial is forfeited.

If Your request for review is received within 180 days, a full and fair review of the claim will be held by the Claims Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

After the review, the Plan's decision will be made to You in writing. It will include specific reasons for the decision as well as specific references to the Plan provisions on which the decision is based. You will be notified of the Plan's decision as follows:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter timeframe;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter timeframe; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

SECOND LEVEL OF APPEAL

If You disagree with the Plan's decision on the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust) by using the procedures outlined below:

Request for Review

Upon completion of the first level of appeal, any participating Covered Employee or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim.

Claim Appeal Procedure – continued

The written request must be submitted to the Claims Review Committee within **ninety (90) days** after receipt of the Plan's decision on the first level of appeal. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Covered Employee or beneficiary wishes to present.

To submit a request for review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee
WCA Group Health Trust
22 East Mifflin Street, Suite 900
Madison, WI 53703

Review

Upon timely receipt of a request for review, the Claims Review Committee will schedule a review of your appeal. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Claims Review Committee will provide that information to You free of charge and sufficiently in advance of the due date of the response to the Your appeal.

Decision

You will be notified of the Claims Review Committee's decision as follows, affirming, modifying or setting aside the previous decision or action:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;
2. The exclusion for experimental or investigational services or unproven services; or
3. As otherwise required by applicable law.

Vision - Effective 1/1/14

Federal External Review Program – continued

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR, Inc., or Your Employer fail to respond to Your appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither You nor UMR, Inc. or Your Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include:

1. Your specific request for an external review;
2. The Employee's name, address, and member ID number;
3. Your designated representative's name and address, when applicable;
4. The service that was denied; and
5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the adverse benefit determination. You, Your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a Covered Expense by the Plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or Your Employer. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or Your Employer in making a decision on the case;
and

Federal External Review Program – continued

3. All other information or evidence that You or Your physician has already submitted to UMR, Inc. or Your Employer.

If there is any information or evidence You or Your physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR, Inc. and/or Your Employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.