PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

FOR

COUNTY OF DAKOTA COUNTY

EMPLOYEE HEALTH BENEFIT PLAN

G - 30071373

PLAN EFFECTIVE DATE:
MARCH 1, 2020

County of Dakota County hereby amends and restates its self-funded health care plan for the benefit of eligible Employees and their eligible Dependents.

The purpose of the County of Dakota County Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the Company's eligible Employees and their eligible Dependents.

The Company caused this instrument to be executed by its duly authorized officers effective as of the 1st day of March 2020.

COUNTY OF DAKOTA COUNTY

By: _____

Title: COMMISSIONER

Date: 3-9-20

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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or Accident. The medical benefits available under the County of Dakota County Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the Company has attempted to provide the best coverage possible within the financial limits of both the Company and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the Company.

The Company has selected Cigna, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact Cigna at least 72 hours prior to any scheduled admission for a medical condition, Mental or Nervous Disorder, Substance Abuse/Substance Dependence treatment, or Outpatient Surgical Procedures. In case of an emergency Hospital admission or emergency surgery, Cigna must be notified within two working days following admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the Cigna pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

PRIOR TO PRE-CERTIFICATION, AN AUDIT NUMBER MUST BE OBTAINED VIA FAX BY CALLING (888) 620-1297.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the Company incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources®, for assistance. Group Resources is always available to assist you with your questions. We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our Company.

PRIVACY AND SECURITY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY AND SECURITY OF MEDICAL INFORMATION" shall also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

Business Associates. The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records. The Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate or for data aggregation services relating to the health care operations of the Plan. The Business Associate may disclose PHI in connection with a function, service or responsibility or service to be performed by the Business Associate and such disclosure is: required by law; or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential, and used or further disclosed only as required by law or for the purposes for which it was disclosed, and the person agrees to notify the Business Associate of any breaches of confidentiality.

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims , or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

DISCLOSURES TO THE COMPANY. The Plan will disclose your medical information to the Company for Plan administration purposes only upon receipt of a certification from the Company that the Plan sets forth the permitted uses and disclosures of medical information by the Company on behalf of the Plan, and that the Company has agreed to the following assurances:

- The Company will not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
- The Company will ensure that any agents, including subcontractors, to whom it provides medical information (including electronic medical information) received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information and agree to implement reasonable and appropriate security measures to protect the information;
- The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Company will not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- The Company will report to the Plan any use or disclosure of medical information that is inconsistent with the permitted uses and disclosures, of which it becomes aware;
- The Company will report to the Plan, within a reasonable time after the Company becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic medical information;
- The Company will report to the Plan any other security incident on an aggregate basis every quarter or more frequently upon the Plan's request;
- The Company will make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- The Company will, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The Company will ensure that there is adequate separation between the Plan and the Company (as described below) and that the separation is supported by reasonable and appropriate security measures;

- The Company will make your medical information available to you (as described below);
- The Company will make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The Company will make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan uses or maintains an electronic health record with respect to your medical information, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to another entity or person.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator, as provided for in 45 C.F.R §164.528 of the HIPAA requirements.

Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COMPANY. Only Employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, *you* may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

VENDOR LISTING

Plan Administrator	County of Dakota County 1601 Broadway Dakota City, NE 68731 (402) 987-2126
Administrative Service Agent	Group Resources 3080 Premier Parkway, Suite 100 Duluth, GA 30097 (800) 749-9963
Pre-Certification Administrator **Prior to pre-certification, an audit number must be obtained via fax by calling (888) 620-1297**	**Cigna**
Prescription Drug Program	Welldyne (888) 886-5822 www.welldynerx.com
Preferred Provider Organization (PPO)	**Cigna** www.mycigna.com

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below.

This Plan treats Mental or Nervous Disorders as any other Illness. For benefits, please check below for the Provider who is performing the services. Substance Abuse/Substance Dependence is not covered.

CALENDAR YEAR DEDUCTIBLE

PPO

Single $1,000
Family $2,000

NON-PPO

Single $4,000
Family $8,000

Eligible expenses are applied to either the PPO or Non-PPO Deductible. The two Deductibles are completely separate.

CARRY OVER DEDUCTIBLE ..... Applies

Charges incurred in October, November, or December of a Calendar Year and applied to the Deductible for that Calendar Year will also apply to the Deductible for the following Calendar Year.

COMMON ACCIDENT DEDUCTIBLE ..... Applies

This provision applies when two or more Covered Persons are Injured in the same accident. These persons need not meet separate Deductibles for treatment of Injuries incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them as a unit.

COINSURANCE (After satisfaction of the Calendar Year Deductible)

PPO 80%
NON-PPO 60%

If a Covered Person is living outside of the PPO network, traveling for business or pleasure outside of the PPO network, or if charges are incurred for treatment of a Medical Emergency (see "DEFINITIONS") which occurs outside of the PPO network, benefits will be processed at the PPO Coinsurance rate subject to the PPO Deductible, PPO Out-of-Pocket, or PPO Copay if the Covered Person utilizes a Multiplan/PHCS PPO Provider/facility.

OUT-OF-POCKET MAXIMUM

PPO

Single $1,200
Family $2,400

NON-PPO

Single $4,400
Family $8,800

The Out-of-Pocket Maximum includes medical Copays.

Eligible expenses are applied to either the PPO or Non-PPO Out-of-Pocket. The two Out-of-Pockets are completely separate. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, the Calendar Year Deductible, penalties and non-covered charges do not apply to the Out-of-Pocket Maximum.

AMBULANCE SERVICES
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS ..... Unlimited

CARDIAC REHABILITATION (Letter of Medical Necessity is required)
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%

CHEMOTHERAPY/RADIATION
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%

CHIROPRACTIC CARE (See Spinal Manipulation)

CURAQUICK (Hy-Vee stores only - Deductible waived) ..... $15 Copay per visit, then 100%

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility - includes professional fees incurred for automated tests)
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%

DURABLE MEDICAL EQUIPMENT (Letter of Medical Necessity is required)
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%

EMERGENCY ROOM SERVICES
- **PPO** (Deductible waived) ..... $150 Copay per visit, then 100%
- **NON-PPO** (Deductible waived) ..... $150 Copay per visit, then 100%

HOME HEALTH CARE (Letter of Medical Necessity is required)
- **PPO** (Deductible applies) 80%
- **NON-PPO** (Deductible applies) 60%
- **Maximum Visits Per Calendar Year** ..... 100 visits

HOSPICE CARE

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%
Maximum ..... 180 days per occurrence or 360 days lifetime

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a $500 penalty will apply)

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

a) for a semi-private room, the average semi-private room rate of the Hospital;
b) for a private room, the average semi-private room rate of the Hospital, or if the Hospital has private rooms only, the maximum eligible charge will be limited to 95% of the actual private room charge;
c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

PPO ..... $30 Copay, then 100% for initial visit, additional visits are subject to Deductible and 80%
NON-PPO (Deductible applies) 60%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

OUTPATIENT SURGERY (Hospital, Outpatient Surgical Center – must be pre-certified or a $500 penalty will apply)

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

PHYSICAL THERAPY (Letter of Medical Necessity is required – benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition within two months of the start of treatment.)

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) ..... 60% up to a maximum of $20 per visit
Maximum Visits Per Calendar Year ..... 24 visits

PHYSICIAN'S SERVICES

Office Visit (Includes Copay includes visit charge, injections, lab, and x-ray)

PPO (Deductible waived) ..... $30 Copay per visit, then 100%
NON-PPO (Deductible applies) 60%

Office Surgery
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%
All Other Services (Services rendered outside of the Physician's office)
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

PULMONARY REHABILITION (Letter of Medical Necessity is required)
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

RENAL/PERITONEAL DIALYSIS
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

SECOND SURGICAL OPINION
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

SKILLED NURSING FACILITY CARE (Letter of Medical Necessity is required)
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%
Maximum Days Per Calendar Year ..... 100 days

SPEECH/OCCUPATIONAL THERAPY (Letter of Medical Necessity is required – benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition within two months of the start of treatment. Speech Therapy is only covered for Injury, Illness, or congenital anomaly.)
PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%

SPINAL MANIPULATION TREATMENT
PPO (Deductible waived) ..... $30 Copay per visit, then 100%
NON-PPO (Deductible applies) 60%
Maximum Visits Per Calendar Year ..... 24 visits

URGENT CARE FACILITY
PPO (Deductible waived) ..... $30 Copay per visit, then 100%
NON-PPO (Deductible applies) 60%

WELLNESS EXPENSE

Colonoscopy

PPO (Deductible waived) 100%
NON-PPO ..... Not Covered

All Other Services

PPO (Deductible waived) 100%
NON-PPO (Deductible applies) 60%

Preventive services are covered with no cost share if a PPO Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, available at https://www.uspreventiveservicestaskforce.org/page/name/uspstf-a-and-b-recommendations;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at http://www.cdc.gov/vaccines/acip/index.html;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at https://www.healthcare.gov/preventive-care-children/; and
- With respect to women, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at http://www.hrsa.gov/ and the expanded women's preventive services, available at http://www.hrsa.gov/womensguidelines/. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

No benefits will be paid for routine exams and related services when rendered solely for purposes of employment, participation in school athletic programs, foreign travel, immigration, the purchase of additional insurance, to obtain or maintain a license of any type, medical research, judicial or administrative proceedings or orders, or marriage or adoption.

WIGS (After chemotherapy and/or radiation)

PPO (Deductible applies) 80%
NON-PPO (Deductible applies) 60%
Lifetime Maximum $500

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

OUT-OF-POCKET MAXIMUM FOR PRESCRIPTION DRUGS

Single	$5,950
Family	$11,900

Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share for generic form; however, Non-Preferred/Preferred contraceptives will have a Copay as long as a generic form is available. For a list of covered preventive services, please visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

WELLDYNERX PRESCRIPTION DRUG PROGRAM. WellDyneRx is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the WellDyneRx prescription drug program in two ways. Short-term prescriptions may be filled at local WellDyneRx Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. WellDyneRx home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local WellDyneRx pharmacy, and another which can be mailed to the WellDyneRx home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Generic	$15
Preferred	$25
Non-Preferred	$45
Certain Over-the-Counter Drugs	$5

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Generic	$30
Preferred	$50
Non-Preferred	$90

Prescriptions not purchased through the mail order or drug card program will not be covered under this Plan. The per prescription Copay is not eligible for reimbursement under the Plan.

HIGH DOLLAR PRESCRIPTION DRUG PROGRAM

MAXIMUM PER PERSON PER PLAN YEAR $10,000

PRESCRIPTION DRUG CARD PROGRAM
Copay For Each Prescription or Refill (30-day supply)
Prescriptions costing in excess of $500 ..... 20% of prescription cost

MAIL ORDER PRESCRIPTION DRUG PROGRAM
Copay For Each Prescription or Refill (90-day supply)
Prescriptions costing in excess of $1,500 ..... 20% of prescription cost

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.
Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.
Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Some drug expenses which are not covered:
* Drugs which can be obtained without a Physician's prescription, except for certain over-the-counter drugs such as: Claritin, Alavert, Loratidine, Prilosec, Pepcid AC, Zantac, Tagamet HP, and Axid AR;
* Charges for the administration or injection of any drug;
* Non-legend drugs;
* Therapeutic devices or appliances, including hypodermic needles, syringes (except the insulin syringes and needles), support garments, and other non-medical substances, regardless of intended use;
* Prescriptions that an eligible person is entitled to receive without charge from any worker's compensation laws, or any municipal, state or federal program;
* Drugs labeled "caution – limited by federal law to investigational use," or an experimental drug, even though a charge is made to the eligible person;
* Immunization agents, biological sera, blood or blood plasma, and blood derivatives;
* Medication which is to be taken by or administered to an eligible person, in whole or in part, while the eligible person is a patient in a licensed hospital;
* A prescription filled or refilled in excess of the number specified by the physician;
* Any refill dispensed after one year from the Physician's original prescription order;
* Drug charges, which are equal to or less than the Copay amount;
* Any service or supply excluded under "EXCLUSIONS AND LIMITATIONS;"
* DESI drugs other than those specifically listed. DESI drugs are those drugs that the FDA has determined to be ineffective;
* Retrovir (Zidovudine, AZT, Azidothymidine) and any future AIDS specific drugs (unless prior approval is obtained through the Plan Administrator);
* Infertility medication;
* Growth hormones;

* Anti-obesity drugs (appetite suppressants);
* Retin A and Ritalin, except for children through age 18;
* Accutane, Avonex, Adderal (unless prior approval is obtained through the Plan Administrator);
* Injectable drugs, other than insulin, insulin syringes/needles;
* Viagra;
* Propecia and other hair growth stimulants; and
* Medications to treat conditions excluded elsewhere.

This is not a complete list of drugs that are excluded. To determine specific drug coverage, please contact WellDyneRx at (888) 886-5822 or www.welldynerx.com.

DENTAL BENEFITS

Benefits are payable only if the covered dental expenses are for treatment that is:

1) Incurred and completed while dental coverage is in effect; and
2) Provided by:
   - A licensed Dentist;
   - A licensed Doctor; or
   - A dental assistant or a Dental Hygienist working under the direct supervision of a Dentist; and
3) Provided according to generally accepted dental practice; and
4) Necessary for the diagnosis, prevention or correction of dental disease, defect or Accidental Injury.

CALENDAR YEAR DEDUCTIBLE PER PERSON

Single $25
Family $75

CALENDAR YEAR MAXIMUM BENEFIT PER PERSON (Excluding orthodontia) $1,250

LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIA
(Coverage for Covered Persons age 8 to 19) $1,000

Percent of Covered Charges Payable

CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES (Deductible waived)..... 100%

CLASS II-BASIC PROCEDURES (Deductible applies)..... 80%

CLASS III-MAJOR PROCEDURES (Deductible applies)..... 50%

CLASS IV-ORTHODONTIA (Deductible applies)..... 50%

CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES

- One routine oral exam each six month period
- One prophylaxis (cleaning) each six month period
- One set of bitewings each 12 month period
- A complete series each three year period unless special need is shown
- Topical application of fluoride for dependent children under age 19 once each 12 month period
- Space maintainers for dependent children under age 19
- Oral hygiene instruction, but not more than once per lifetime

CLASS II – BASIC PROCEDURES

- Emergency treatment for pain
- Fillings (amalgam, synthetic porcelain, and plastic)
- Stainless steel crowns

- Sealants for dependent children age 15 and under once per tooth per lifetime
- Oral surgery
  - Tooth extractions and other oral surgery, including pre and post operative care, alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and retreatment of simple compound fractures
- Periodontics
  - Non-surgical: procedures necessary for the treatment of diseases of the gums. Coverage is limited to one non-surgical periodontal treatment per quadrant every 24 months; and
  - Surgical: surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth. Coverage is limited to one treatment per quadrant every 36 months
- Endodontics
  - Pulpotomies on primary teeth for Dependent children and root canal therapy – no coverage is provided for retreatment)

CLASS III - MAJOR PROCEDURES

- Crowns, inlays, and onlays
- Gold fillings when other filling materials cannot be used
  - Replacement of a crown, inlay, or onlay will be provided only after a five year period measured from the date on which the procedure was last covered by the Plan
- Bridges, partial dentures, and complete dentures
  - Benefit for the replacement of prosthetics will be provide only after five years have elapsed from when last covered and then only in the event that the existing appliance is not and cannot be, made satisfactory. Coverage is not provided for replacement of an existing partial denture with a bridge

CLASS IV - ORTHODONTIA

This is treatment to move teeth by means of appliances, to correct a handicapping malocclusion of the mouth. Services include preliminary study and treatment plan, x-rays, diagnostic casts, active treatment and retention appliance. Payments for comprehensive full-banded orthodontic treatments are made in installments.

ALTERNATE TREATMENT. Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefits payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

RECONSTRUCTIVE SURGERY. Benefits will be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from Injury, Illness, or other diseases of the involved part, when such dental procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician, provided that such procedures are dental reconstructive surgical procedures.

COVERED CHARGES. Covered Charges will be the actual cost charged for the treatment or service for a dental condition, but not more than the Reasonable Charge or Customary Charge.

If it is determined that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the least expensive of the procedures that would provide professionally acceptable results.

BEGINNING DATE FOR TREATMENT OR SERVICE. Treatment or service will be considered to begin:

1) For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
2) For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
3) For full or partial dentures, on the date the master impression is made; or
4) For all other services, on the date the treatment or service is performed.

LIMITATIONS AND EXCLUSIONS. Dental benefits will <u>not</u> be paid for:

1) Treatment or service that is covered by a workers' compensation or occupational disease or similar law;
2) Treatment or service for which the Covered Person has no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States government or one of its agencies;
3) Cosmetic dental work;
4) Services of Anesthesiologists;
5) Services which are not included in "DENTAL BENEFITS";
6) Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting, and gnathologic recording;
7) Direct diagnostic, surgical or non-surgical treatment procedures applied to body joints or muscles,; except as provided under orthodontics;
8) Implants (artificial materials implanted or grafted into or onto bone or soft tissue) or surgical removal of implants;
9) Veneers (bonding of coverings to teeth);
10) Consultations and office visits;
11) Temporary procedures;
12) Athletic mouth guards, splints or occlusal guards;
13) Re-treatment or additional treatment necessary to correct or relieve the results of previous treatment;
14) Removable unilateral dentures;
15) Crown lengthening;

16) Procedures performed by other than licensed Dentist or his/her employees or agents; and
17) Repair or replacement of any orthodontic appliance (fixed or removable).