

MEDICAL AND PRESCRIPTION DRUG PLAN

MASTER PLAN DOCUMENT

CITY OF MILWAUKEE

Medicare-Eligible Retired Employees and
Medicare-Eligible Dependents

EFFECTIVE DATE OF THE PLAN: JANUARY 1, 2009

Anthem is an independent licensee of the
Blue Cross and Blue Shield Association in the State of Wisconsin

CITY OF MILWAUKEE

**MASTER PLAN DOCUMENT FOR SELF-FUNDED
GROUP MEDICAL AND PRESCRIPTION DRUG BENEFITS**

Medicare-Eligible Retired Employees and
Medicare-Eligible Dependents

To be effective **January 1, 2009**, **City of Milwaukee** adopts this Master Plan Document which includes Group Medical and Prescription Drug Benefits.

City of Milwaukee adopts and accepts this Master Plan Document.

Date

Signature

Print or Type Name

Witness Name

TABLE OF CONTENTS

COVERED PERSON'S RIGHTS AND RESPONSIBILITIES	1
HEALTH CARE MANAGEMENT	3
INFORMATION REGARDING THE BLUE CARD PROGRAM	6
SCHEDULE OF BENEFITS	7
<i>Individual Deductible</i>	<i>7</i>
<i>Coinsurance Paid By The Plan.....</i>	<i>7</i>
<i>Eligible Basic Benefits</i>	<i>7</i>
MAJOR MEDICAL BENEFITS	10
<i>Individual Deductible</i>	<i>10</i>
<i>Family Deductible Limit</i>	<i>10</i>
<i>Coinsurance Paid By The Plan.....</i>	<i>10</i>
<i>Hospital Care.....</i>	<i>10</i>
<i>Specialty Hospital Care</i>	<i>10</i>
<i>Skilled Nursing Facility</i>	<i>10</i>
<i>Home Health Care</i>	<i>11</i>
<i>Special Duty Nursing</i>	<i>11</i>
<i>Therapy.....</i>	<i>11</i>
<i>Dental Services</i>	<i>11</i>
<i>Temporomandibular Joint Dysfunction</i>	<i>11</i>
<i>Outpatient Treatment of Mental Health and Substance Abuse</i>	<i>11</i>
MAXIMUM BENEFITS – APPLICABLE ONLY TO MAJOR MEDICAL BENEFITS	12
PRESCRIPTION DRUG BENEFITS.....	13
<i>Prescription Drug Co-payment Amounts.....</i>	<i>13</i>
ELIGIBILITY FOR COVERAGE AND EFFECTIVE DATE OF COVERAGE.....	14
ELIGIBLE RETIREES AND DEPENDENTS.....	14
EFFECTIVE DATE OF COVERAGE	14
TERMINATION OF COVERAGE	15
PRE-EXISTING CONDITION LIMITATION.....	23
BASIC AND MAJOR MEDICAL BENEFITS.....	27
PROFESSIONAL CHARGES	27
SURGICAL SERVICES	27
PODIATRY SERVICES	27
ORAL SURGERY.....	28
ANESTHESIA.....	28
MATERNITY CHARGES	28
NEWBORN COVERAGE.....	28
EDUCATION AND TRAINING SERVICES	29
HOSPITAL AND SPECIALTY HOSPITAL ROOM AND BOARD	29
HOSPITAL MISCELLANEOUS CHARGES	29
OUTPATIENT FACILITY SERVICES.....	29
HUMAN ORGAN AND TISSUE TRANSPLANT	29
SKILLED NURSING FACILITY	30
EQUIPMENT AND TREATMENT OF DIABETES	30
HOME HEALTH CARE	30

TABLE OF CONTENTS

HOSPICE CARE	31
INPATIENT, OUTPATIENT AND TRANSITIONAL TREATMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE	31
SUPPLEMENTAL ACCIDENT BENEFIT	32
CHIROPRACTIC CARE	32
THERAPY	32
AMBULANCE	32
TEMPOROMANDIBULAR JOINT DYSFUNCTION	32
OTHER COVERED TREATMENT, SERVICES AND SUPPLIES.....	32
LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN	35
PRESCRIPTION DRUG BENEFITS.....	40
LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION DRUG BENEFITS	41
COORDINATION OF BENEFITS.....	43
DEFINITIONS.....	43
EFFECT ON BENEFITS	44
ORDER OF BENEFITS DETERMINATION	44
RIGHT TO NECESSARY INFORMATION	45
COORDINATION OF BENEFITS WITH MEDICARE	45
FACILITY OF PAYMENT.....	45
COORDINATION UNDER THE BLUECARD PROGRAM.....	45
HOW TO FILE A CLAIM	46
GENERAL TERMS AND DEFINITIONS	48
GENERAL INFORMATION.....	55
ADMINISTRATION OF THE PLAN.....	55
CALCULATION OF PLAN MAXIMUM AMOUNTS	55
CLERICAL ERROR	55
COMMON ACCIDENT DEDUCTIBLE	55
CONFORMITY WITH GOVERNMENT LAW.....	55
COST SHARING PROVISIONS	56
DUPLICATION OF BENEFITS	57
FINANCING AND ADMINISTRATION	57
MASTER PLAN DOCUMENT	57
MEDICAL CARE PROVIDED BY THE UNITED STATES	57
NEW DRUGS, MEDICAL TESTS, DEVICES AND PROCEDURES	57
PARTICIPANT CONTRIBUTION.....	57
PAYMENTS DIRECTLY TO PROVIDERS.....	57
PAYMENTS MADE PRIOR TO DETERMINING FINAL LIABILITY	57
PHYSICAL EXAMINATION	58
PLAN AMENDMENT OR TERMINATION.....	58
PLAN INTERPRETATION	58
PLAN IS NOT A CONTRACT	58
PLAN MAXIMUMS AND BENEFIT MAXIMUMS.....	58
SUBROGATION AND REIMBURSEMENT.....	59
PRESUMPTION OF RECEIPT OF INFORMATION	61
PREVENTIVE SERVICES.....	61
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION	61

TABLE OF CONTENTS

PROOF OF CLAIM..... 64
RESCISSION OF COVERAGE..... 64
RIGHT OF RECOVERY FOR PAYMENTS MADE..... 64
RIGHTS WITH RESPECT TO MEDICAID 65
SELF-FUNDING 65
SUMMARY PLAN DESCRIPTIONS 65
USUAL AND CUSTOMARY PROCEDURE..... 65
WORKERS' COMPENSATION..... 66
YOUR RIGHT TO APPEAL 66
PLAN INFORMATION..... 69

COVERED PERSON'S RIGHTS AND RESPONSIBILITIES

As a Covered Person, You Have the Right to:

- Receive information about the organization and its services, practitioners and Providers, and Covered Persons' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Physician in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from the Third Party Administrator, and to have the Third Party Administrator, on behalf of the Employer, investigate and take appropriate action;
- File a complaint with the Third Party Administrator to appeal that decision as outlined in the **Your Right to Appeal** in the General Information section of this Benefit Booklet, and to appeal a decision without fear of reprisal; and
- Privacy and confidential handling of your information;
- Make recommendations regarding the Third Party Administrator's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Covered Person, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information the Third Party Administrator needs to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;
- Notify your Provider or the Third Party Administrator about concerns you have regarding the services or medical care you receive;
- Keep appointments for care and give reasonable notice of cancellations;

COVERED PERSON'S RIGHTS AND RESPONSIBILITIES

- Be considerate of other Covered Persons, Providers and the Third Party Administrator's staff;
- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Third Party Administrator or Employer concerning your health benefits;
- Provide accurate and complete information to the Third Party Administrator about other health care coverage and/or insurance benefits you may carry; and
- Inform the Third Party Administrator and the Employer, of changes to your name, address, phone number, or if you want to add or remove Dependents.

HEALTH CARE MANAGEMENT

Health Care Management includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review. Its purpose is to promote the delivery of cost-effective medical care to all Covered Persons by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Covered Persons the Third Party Administrator serves. These processes are described in the following section.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number on your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify The Third Party Administrator within 24 hours or next business day of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Third Party Administrator will review your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review– A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Third Party Administrator has a related clinical coverage guideline and are typically initiated by the Third Party Administrator.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Customer Service telephone number on your Identification Card.

Request Categories:

- **Urgent** – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or subject the

Covered Person to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent** - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. If a state regulation is applicable, we will comply with any quicker time frames set forth therein. You may call the telephone number on your Identification card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Third Party Administrator will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If The Third Party Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Third Party Administrator’s possession.

The Third Party Administrator will provide notification of its decision in accordance with federal regulations. Notification may be given by the following methods:

Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.

Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Covered Person or authorized Covered Person's representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. you must be eligible for benefits;
2. the service or surgery must be a covered benefit under your Plan;
3. the service cannot be subject to an exclusion under your Plan, including but not limited to a Pre-Existing Condition limitation or exclusion; and
4. you must not have exceeded any applicable limits under your Plan.

Care Management

Care Management is a Health Care Management service designed to help promote the timely coordination of services for Covered Persons with health-care related needs due to serious, complex, and/or chronic medical conditions. The Third Party Administrator's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Covered Persons who are invited and agree to participate in the Care Management Program.

Care Management programs are confidential and voluntary. These programs are provided at no additional cost to You and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Covered Persons who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Covered Person and/or Covered Person's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Covered Person by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Covered Person's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

INFORMATION REGARDING THE BLUE CARD PROGRAM

Information Regarding The BlueCard Program

Anthem is able to offer the Plan participation in a program called “BlueCard”. Blue Cross and Blue Shield Licensees (including Anthem), participate in a program called "BlueCard". Whenever a covered person accesses health care services outside the geographic area served by Anthem, the claims for those services may be processed through BlueCard and presented to Anthem for payment on behalf of the Plan, in conformity with the network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when a covered person receives covered services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), Anthem will remain responsible to the Plan for fulfilling all contract obligations. However, in accordance with any applicable BlueCard Policies, the Host Blue will only be responsible for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described in further detail in the Cost Sharing Provisions located in the General Information section of the Plan. To find a PPO BlueCard provider visit www.anthem.com or call 1-800-810-2583.

SCHEDULE OF BENEFITS

The outline of benefits in this schedule is a summary of coverage provided by the Plan. A detailed explanation of the benefits is provided in the pages which follow.

Benefits listed in the Plan are limited to the Usual and Customary fees and subject to the Limitations and Exclusions specified in the Plan.

All inpatient Hospital admissions are subject to the provisions of the Health Care Management program.

Basic Benefits

Individual Deductible

None

Coinsurance Paid By The Plan

Unless otherwise specified, after satisfaction of the deductible amount eligible charges are covered at 100%

Eligible Basic Benefits

The following charges are covered, subject to the Basic Benefit Coinsurance Paid by the Plan and limited as specified by the Plan.

Professional charges, excluding those for mental health, substance abuse, therapy (physical, speech, occupational, and respiratory), cardiac rehabilitation, special duty nursing, treatment of TMJ, ambulance, and transplants. Eligible charges include services for surgery, inpatient medical services, radiation and chemotherapy, maternity services, x-ray and laboratory, anesthesia, diagnostic services, emergency services, oral surgery services (only those identified by the Plan as eligible oral surgeries), and podiatry services. **Professional services not addressed may be covered under the major medical benefits.**

Hospital charges, excluding those for mental health and substance abuse and transplants. Hospital charges include inpatient and outpatient care for emergency medical care, surgical procedures, diagnostic x-ray and laboratory services, radiation and chemotherapy, hyperbaric oxygen therapy. Inpatient hospital charges are limited to a maximum of 365 days per period of disability and 120 days in a specialty hospital. The 120 days are in addition to the 365 day per period of disability. **Hospital services not addressed may be covered under the major medical benefits.**

SCHEDULE OF BENEFITS

Education and training services when the education and training is for a medical condition for which education/training is appropriate and the educate/training is received in conjunction with other health care services provided by the hospital for that medical condition such as with a surgery or inpatient hospitalization. Also, allowable under this benefit are pharmacy charges for counseling, training, and education for treatment of diabetes.

Kidney Disease is limited to \$30,000 per calendar year. No further benefits are available under the Major Medical section of the Plan

Transplants are limited to those that are non-experimental and non-investigational and are subject to the following limits per covered transplant procedure: \$10,000 for private duty nursing, \$10,000 for donor searches and procurement including surgical removal, preservation, and transportation of the donated part, and \$2,000 for ambulance services. Transplants are limited to \$500,000 for all services while covered under the Plan. No further benefits are available under the Major Medical section of the Plan

Skilled Nursing Facility is limited to 30 days per confinement. Additional benefits are available under the major medical benefits.

Equipment and Treatment of Diabetes

Home Health Care Services are limited to 40 visits per calendar year. Additional visits are available under the major medical benefits.

Hospice Care

Inpatient, Transitional and Outpatient Treatment of Mental Health and Substance Abuse

No further benefits are available under the Major Medical section of the Plan

Inpatient Treatment of Mental Health and Substance Abuse

- The deductible amount does not apply
- Amount paid by the Plan: 100%
- Limited to a maximum of 60 days per covered person per calendar year. This benefit is renewed after 120 days.
- No further benefits are available under the Major Medical section of the Plan

Outpatient Treatment of Mental Health and Substance Abuse

- The deductible amount does not apply
- Amount paid by the Plan: 100%
- Limited to a maximum of \$2,000 per covered person per calendar year.

SCHEDULE OF BENEFITS

- Additional benefits are available after the above maximum has been met under the Major Medical section of the Plan

Benefit Determination:

- For purposes of this calendar year maximum, one day of transitional treatment shall count as one-half day of inpatient treatment.
- The determination of whether a claim for benefits is covered by and subject to the Mental Health benefit shall be made without regard to whether the cause of the condition for which treatment and supplies were provided is, or was, organic in origin.

Immunizations including diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hemophilus influenza B, hepatitis B, and varicella.

Blood tests to detect lead exposure in children under six years of age, as may be required or indicated by applicable medical protocols.

Infertility diagnostic services payable only for services directly related to the covered person. Such services are limited to charges for diagnostic services only and do not include laparoscopic procedure during which an ova is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes. No further benefits are available under the Major Medical section of the Plan

Intrauterine devices (IUD) and their placement.

Routine (wellness), including Well baby services, such as exams, pap smears and mammograms, immunizations and blood lead tests for children.

Supplemental Accident Benefit

Hospital or ambulatory surgical center and for anesthesia charges provided in conjunction with dental care if any of the following apply:

- a) the covered person is under age five;
- b) the covered person has a medical condition that requires hospitalization or general anesthesia for dental care; or
- c) the covered person has a chronic disability which meet all of the following conditions:
 - it is attributable to mental or physical impairment or combination of mental and physical impairments;
 - it is likely to continue indefinitely; and
 - it results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency.

SCHEDULE OF BENEFITS

Major Medical Benefits

Benefits listed in the Basic Benefits with additional Major Medical Benefits will continue as specified in this Major Medical Benefit section. Also, eligible charges not listed in the Basic Benefits section that are covered as described in the Plan will be covered under the Major Medical Benefits specified below.

Individual Deductible

\$50 per person per calendar year

Family Deductible Limit

\$100 per family per calendar year

Eligible charges for Family Members who are covered under the Plan may be applied toward satisfaction of the family deductible limit, however, no more than \$50 on any one individual will be applied toward the family deductible limit.

Coinsurance Paid By The Plan

Unless otherwise specified, after satisfaction of the deductible amount eligible charges are covered at 80% up the maximum amount while covered under the Plan for major medical benefits.

Hospital Care

- The deductible amount applies
- Amount paid by the Plan: 80%
- This benefit applies after the covered person has exhausted the maximum number of days available under the Basic Benefits

Specialty Hospital Care

- The deductible amount applies
- Amount paid by the Plan: 80%
- Limited to a maximum of 90 days during any one period of disability. A period of disability shall be the total of all successive skilled nursing facility confinements separated by not less than 180 days.

Skilled Nursing Facility

- The deductible amount applies
- Amount paid by the Plan: 80%
- Limited to a maximum of 90 days per period of disability. A period of disability shall be the total of all successive skilled nursing facility confinements separated by not less than 180 days.

SCHEDULE OF BENEFITS

Home Health Care

- The deductible amount applies
- Amount paid by the Plan: 80%
- Limited to a maximum of 40 visits per calendar year

Special Duty Nursing

- The deductible amount applies
- Amount paid by the Plan: 80%

Therapy

- The deductible amount applies
- Amount paid by the Plan: 80%
- Includes physical, speech, occupational, or respiratory

Dental Services

- The deductible amount applies
- Amount paid by the Plan: 80%
- Dental services are limited to the extraction of seven or more teeth upon recommendation of a physician, provided such extraction occurs within 90 days of such recommendation and initial replacement of natural teeth provided such dental services are the result of injury, provided such services commence within 90 days of such injury.

Temporomandibular Joint Dysfunction

- The deductible amount applies
- Amount paid by the Plan: 80%
- Oral surgery benefits are not covered under this provision. Refer to the oral surgery benefits of the Plan. Benefits for charges for the fitting and installation of corrective splints are limited to a maximum of \$1,250.00 per calendar year.

Outpatient Treatment of Mental Health and Substance Abuse

- The deductible amount does not apply
- Amount paid by the Plan: \$2,000 per covered person per calendar year paid at 80%
- No additional benefits are available under this Plan after the above maximum has been met for the remainder of that calendar year.

Maximum Benefits – Applicable Only to Major Medical Benefits

Maximum Benefits are applicable for the total period of time in which covered by the Plan.

Any amounts paid by the Plan through the Prescription Drug Benefits program will reduce the Maximum Benefits amount.

All paid medical benefits - \$500,000 per person, except as specified below

Transplants are limited to \$500,000 while covered under the Plan.**

**This amount is included in, and is not in addition to, the all paid medical benefits amount specified above.

Upon providing evidence of good health satisfactory to the employer, that a covered person has not received hospital services, professional services, or other services or medical attention or treatment during a period of 180 consecutive days, the plan will restore the maximum benefit as follows:

- After each such six month period, the Plan will restore 33 1/3% of the covered person's maximum benefit;
- The restoration of the maximum will be granted only when satisfactory evidence is provided within 2 years after the six continuous months referenced above; or
- The total maximum benefit available at one time following a restoration shall not exceed \$500,000.

Prescription Drug Benefits

Eligible prescription drugs are payable after satisfaction of the following co-payments:

Prescription Drug Co-payment Amounts

Retail Program

- No deductible amount, 80%

Mail Order Program

- No deductible, 80% of the first two months. The third month is covered at 100%.

Dispensing Limitations

Retail

Dispensing Limitation: Not to exceed a 30-day supply. However, birth control medications can be obtained in a 3-month supply from the retail location. The coinsurance will apply to all three months.

Single-packaged items are limited to two items per coinsurance or a thirty-day supply whichever is more appropriate, as the Prescription Benefits Manager (PBM) determines.

Prior authorization may be required for certain prescription drugs. A list of prescription drugs that require pre-authorization is available from the PBM.

The PBM reserves the right to designate some over-the-counter drugs as eligible under the plan, overriding the exclusion.

Self-administered injectables must be obtained from a PBM network pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

Mail Order Program

Dispensing Limitation: Not to exceed a 90-day supply

Prior authorization may be required for certain prescription drugs. A list of prescription drugs that require pre-authorization is available from the PBM.

Self-administered injectables and narcotics are among those for which a 90-day supply is not available.

The PBM reserves the right to designate some over-the-counter drugs as eligible under the plan, overriding the exclusion.

Self-administered injectables must be obtained from a PBM network pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

ELIGIBILITY FOR COVERAGE AND EFFECTIVE DATE OF COVERAGE

Eligible Retirees and Dependents

All retired Medicare-eligible employees and all covered Medicare-eligible dependents as specified by the employer for the duration specified by the employer.

Effective Date of Coverage

Each employee who is an eligible employee and each eligible dependent may become effective for coverage as specified by the employer. Written application to elect coverage under the Plan must be made no later than 30 days after the effective date of coverage. If coverage under the Plan is elected after the time period specified above, the retired employee may not make application unless specified by the employer.

TERMINATION OF COVERAGE

An employee's or dependent's coverage will terminate upon the earliest of the following occurrences:

1. the date specified by the employer;
2. the date on which the employee or dependent cease to be in a class eligible for coverage as specified by the employer;
3. the effective date on which a modification of the Plan terminates coverage for the class of employees or dependents to which the employee or dependent belongs;
4. the date of termination of the Plan;
5. the date on which the employee designates to terminate coverage under the Plan;
6. the end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due;
7. as to any particular benefit, the effective date on which coverage for the benefit is eliminated by amendment to the Plan; or
8. the date as stated in the provision entitled "Rescission of Coverage" in the General Information section of the Plan.

COBRA CONTINUATION COVERAGE

This COBRA continuation coverage section of the Plan is intended to comply with and satisfy the Notice requirements of § 2590.606-1(e) of title 29 of the Federal Regulations.

This COBRA continuation coverage section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section will generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;

COBRA CONTINUATION COVERAGE

2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Qualifying Event: FMLA

If an employee does not return to work at the end of the employee's leave under the Family and Medical Leave Act or states that he/she will not be returning at the end of the leave period and the employee was covered under the Plan on the day before the first day of the leave or became covered during the leave, the employee will, on the first day after the end of his/her leave of notice of intention not to return to employment (as appropriate), be deemed to have experienced a "Qualifying Event" for purposes of COBRA continuation coverage if in the absence of COBRA continuation coverage the employee would lose coverage under the Plan before the end of the maximum coverage period. A qualifying event will not occur if coverage is eliminated under the Plan on or before the last day of the Employee's leave for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken leave.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must notify the Plan Administrator upon the occurrence of any of these qualifying events.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice on a timely basis that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation

COBRA CONTINUATION COVERAGE

coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Election of Coverage

Each dependent who is a Qualified Beneficiary has an independent right of election under the Plan. If either the Covered Employee or the Qualified Beneficiary who is the spouse of a Covered Employee makes an election for COBRA continuation coverage but does not specify whether the election is for single or other coverage, then the election will be deemed to cover all eligible Qualified Beneficiaries. If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a

COBRA CONTINUATION COVERAGE

guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In general, a Qualified Beneficiary is only entitled to elect the same type of coverage in effect immediately before the Qualifying Event. However, a Qualified Beneficiary has the same right to change from family to single coverage.

A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, COBRA continuation coverage is subject to the Qualified Beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate a Qualified Beneficiary's COBRA continuation coverage retroactively if the Qualified Beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA Beneficiaries the coverage under the Plan will be modified in the same manner for all Qualified Beneficiaries covered under the Plan.

COBRA continuation coverage commences on the day of the Qualifying Event if COBRA continuation coverage is properly elected and the applicable premium is paid as specified herein.

If a Qualified Beneficiary initially elects not to continue coverage under COBRA, the Qualified Beneficiary may revoke that non-election of COBRA continuation coverage at any time during the 60 day election period. The Plan, however, will only provide COBRA continuation coverage beginning with the date of the revocation of the non-election and not retroactively to the date of the actual Qualifying Event. This will result in a lapse of continuous coverage under the Plan. Qualified Beneficiaries must provide notice of the election of COBRA continuation coverage in writing.

If COBRA Continuation Coverage is rejected in favor of alternate coverage under the Plan, COBRA Continuation Coverage will not be offered at the end of that period. If alternate coverage is offered, the COBRA Continuation Coverage period will be reduced to the extent such coverage satisfies the requirement of COBRA. Alternate Coverage may include, for example, continuation by USERRA or any other Plan provision or retiree coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Text telephone callers (those who may be deaf, hard of hearing or speech impaired) may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the 18, 29 or 36 month period for the following reasons:

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for COBRA continuation coverage is not paid by the Qualified Beneficiary on a timely basis or within any applicable grace period.

COBRA CONTINUATION COVERAGE

3. The Qualified Beneficiary becomes covered under another group health plan or entitled to Medicare (either Medicare Part A or Part B, whichever comes first) after the date of the Qualified Beneficiary's election, even if that coverage is different than coverage currently in place. If the Qualified Beneficiary has a condition which is not covered under the other group health plan because the other group health plan contains a pre-existing condition limitation, then the Qualified Beneficiary may continue COBRA continuation coverage under the Plan for the period of time which he or she is denied coverage under the other group health plan for the pre-existing condition, but no longer than the COBRA continuation coverage period for which the Qualified Beneficiary is eligible. (Coverage under the Plan will not be permitted if the other group health plan contains a pre-existing condition exclusion or limitation which does not apply to the Qualified Beneficiary by reason of the other group health plan's portability, access and renewability provision restricting the application of the pre-existing condition limitation.)
4. The Plan terminates coverage on the same basis that the Plan terminates coverage of similarly situated non-COBRA Qualified Beneficiaries.
5. For a Qualified Beneficiary who has continued COBRA continuation coverage due to Social Security Administration Disability status as a Covered Employee or as a Covered Dependent of a Covered Employee, the date on which the Qualified Beneficiary is no longer considered to be disabled by the Social Security Administration. However, such a determination does not allow termination of the COBRA continuation coverage of a Qualified Beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension. In this case the Qualified Beneficiary must notify the Plan Administrator within 30 days of the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. COBRA continuation coverage will be terminated on the first day of the month following 30 days after the date of the Social Security Administration's determination.
6. The Qualified Beneficiary is determined to have been ineligible for coverage under the Plan or is determined not to be a Qualified Beneficiary.

Payment of Premium

The Plan may require payment of a premium for COBRA continuation coverage. The premium will not exceed 102% of the applicable premium for the period in question except for the 11 months of a disability extension. If the disabled Qualified Beneficiary is qualified for and elects the disability extension, a premium not to exceed 150% of the applicable premium may be charged. If only the non-disabled family members of the disabled Qualified Beneficiary elect the disability extension, then they will be charged a premium not to exceed 102% of the applicable premium. In addition, the premium payment for the first 30 days for an employee who is eligible for coverage under the Uniformed Services Employment and Re-employment Rights Act of 1994 must be the same as for an active employee. Thereafter, the premium amount will not exceed 102% of the applicable premium for the remaining 17 months.

Determination of the applicable premium will be made in advance and will apply for a period of 12 months, the date being established by the employer, unless: 1.) The Plan has previously charged less than the maximum amount it is permitted to charge and the increased amount does

COBRA CONTINUATION COVERAGE

not exceed the maximum amount permitted to be charged; or 2.) The increase occurs during the disability extension and the increased amount to be paid does not exceed the maximum amount permitted to be charged; or 3.) A Qualified Beneficiary changes the coverage being received.

The premium will be based in part, on a reasonable estimate of the cost of providing coverage for the period for similarly situated active employees or on the basis of past costs of providing such coverage.

The employer must allow the Qualified Beneficiary or a third party to pay for such COBRA continuation coverage on a monthly basis. The Qualified Beneficiary has 45 days from the date on which the Qualified Beneficiary makes a written election of COBRA continuation coverage to pay for the first month's premium. The initial premium payment must include all past amounts to the date of election and shall apply to the period of COBRA continuation coverage beginning immediately after the coverage under the Plan terminates except for cases where the Qualified Beneficiary does not elect to continue coverage and then revokes that non-election.

The Plan is not required to pay for any claims incurred prior to a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage, however, such claims shall be eligible for payment upon timely election of such COBRA continuation coverage and proper premium payment for the COBRA continuation coverage.

After the first month's COBRA continuation coverage under COBRA, the Qualified Beneficiary has a 30 day grace period from the first day of the coverage period in which to make payment. The employer or Plan Administrator will not send a bill each month. The Qualified Beneficiary or designated representative, is required to remit payment of the applicable premium to the employer or to the address specified in the COBRA notice on the date established by the employer. If payment is not received within the amount of time specified by the employer, and after the grace period has expired, COBRA continuation coverage will terminate. If the premium payment made by the Qualified Beneficiary is short an insignificant amount or less, the Qualified Beneficiary will receive a notice of the deficiency and will have 30 days from the date of the notice for the deficiency to be paid.

If payment is made by check and that check is returned to the employer by the bank on which such payment is drawn for Non-Sufficient Funds, the Qualified Beneficiary has until the end of the applicable grace period to properly fund this payment. A check returned to the employer for any reason that is not funded prior to the end of the grace period will not be considered to be a timely payment of the applicable premium and COBRA continuation coverage under the Plan will terminate.

For purposes of COBRA continuation coverage, all benefits provided by this Plan shall be deemed to be one, single plan. (Short Term Disability and Long Term Disability benefits, if any, shall not be deemed a part of this Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US

COBRA CONTINUATION COVERAGE

Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Plan Administrator. Please refer to the Plan Information section of the Plan for the address and telephone number of the Plan Administrator.

PRE-EXISTING CONDITION LIMITATION

Definitions

The following terms will have the definitions indicated below for purposes of this Pre-existing Condition Limitation section.

"Affiliation Period" means a period of time that must expire before health insurance coverage becomes effective.

"Certificate of Coverage" means a document provided by the group health plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the Covered Person that indicates the amount of Creditable Coverage the individual acquired under the plan or the group health coverage.

"Creditable Coverage" means coverage of an individual under any of the following:

- (i) A group health plan as defined in § 2590.732(a).
- (ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).
- (iii) Part A or B of Title XVIII of the Social Security Act (Medicare).
- (iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
- (v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).
- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means:
 - (A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;
 - (B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or
 - (C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition:
 - (1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or
 - (2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

PRE-EXISTING CONDITION LIMITATION

- (viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).
- (ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.
- (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Enrollment Date" means, with respect to a Covered Person the earlier of, the individual's first day of coverage in the Plan, or with respect to a person who is eligible for coverage, the individual's first day of a Waiting Period, if there is a Waiting Period.

"Excluded Coverage" means:

1. coverage consisting of coverage only for accidents "including" accidental death and "dismemberment", disability income insurance, liability insurance "including" general liability insurance and automobile liability insurance, coverage issued as a supplement to a liability policy, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance and coverage for an on-site medical clinic;
2. coverage provided by limited scope dental, vision or long term care benefits if they are provided in a separate policy, certificate or contract of insurance or are otherwise not an integral part of a plan;
3. coverage for only a specified disease or illness or Hospital indemnity or other fixed dollar indemnity insurance; or
4. medical supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act also known as "Medigap" or "MedSupp" insurance.

"Late Enrollee" means an individual who enrolls for coverage under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan; or
2. a special enrollment period. [See "Special Enrollment Provisions" in the Effective Date of Coverage section of the Plan.]

"Pre-existing Condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, prescription drugs, care or treatment was recommended or received within the preceding 180 day period ending on the enrollment date. Such medical advice, diagnosis care or treatment must have been

PRE-EXISTING CONDITION LIMITATION

provided by a health care provider or practitioner duly licensed to provide such care under state law and operating within the scope of practice authorized by state law.

"Significant Break in Coverage" means a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage. Neither a Waiting Period nor an Affiliation Period is taken into account in determining a significant break in coverage.

"Waiting Period" means the period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

Pre-existing Condition Limitation

The Covered Person is not covered for a Pre-existing Condition until 270 days after the Covered Person's Enrollment Date.

Elimination of the Pre-existing Condition Limitation for Pregnancy and Certain Children

No Pre-existing Condition Limitation shall be imposed in the case of a Covered Person who, as of the last day of the 31-day period beginning with his or her date of birth was, covered under Creditable Coverage, unless such person would have a Significant Break in Coverage.

No Pre-existing Condition Limitation shall be imposed in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 31 day period beginning on the date of the adoption or placement for adoption, was covered under Creditable Coverage, unless such person would have a Significant Break in Coverage. Creditable Coverage shall not be recognized for coverage that occurred before the date of such adoption or placement for adoption.

NOTE: The preceding two paragraphs shall not apply to an individual after the end of the first 63-day period during all of which the individual had not been covered under any Creditable Coverage.

Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition relating to such information.

No Pre-existing Condition Limitation shall be imposed relating to pregnancy as a Pre-existing Condition.

No Pre-existing Condition Limitation shall be imposed on a covered newborn or a covered adopted child provided written application for coverage under the Plan was made for the child when first eligible.

Creditable Coverage

The period of any Pre-existing Condition Limitation under the Plan that would otherwise apply to a Covered Person is reduced by the number of days of Creditable Coverage such individual had as of the enrollment date subject to the following:

PRE-EXISTING CONDITION LIMITATION

1. days of Creditable Coverage that occur before a Significant Break in Coverage will not be counted toward satisfying any Pre-existing Condition Limitation provision of the Plan;
2. the amount of Creditable Coverage is determined by counting all of the days the individual had Creditable Coverage from one or more sources, provided that any days in a Waiting Period for a plan or policy are not considered Creditable Coverage under the Plan; and
3. any coverage that is "Excluded Coverage" shall not be included as Creditable Coverage.

Evidence of Creditable Coverage

In determining the validity and amount of Creditable Coverage (and any applicable Waiting Period), the Plan may rely upon a Certificate of Coverage evidencing Creditable Coverage through presentation of a document or other means. The Plan may also, when an acceptable Certificate of Coverage is unavailable, take into account all information that it obtains or that is presented on behalf of a Covered Person to make a determination, based on the relevant facts and circumstances, whether a Covered Person has Creditable Coverage. The Plan shall treat the individual as having furnished a Certificate of Coverage if the individual attests to the period of Creditable Coverage in a manner acceptable to the Plan, the individual also presents relevant corroborating evidence of some Creditable Coverage during the period, and the individual cooperates with the Plan's efforts to verify the individual's coverage.

A Covered Person has a right to receive a Certificate of Coverage from the individual's prior plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the Covered Person. If necessary, the Plan will assist the Covered Person in obtaining a Certificate of Coverage from any prior plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the Covered Person.

Procedure for Certificates of Coverage

An individual who wishes to receive a Certificate of Coverage for periods under this Plan should contact the Plan Administrator whose address is given in the "Plan Information" section of the Plan.

Appeal Process for Determination of Creditable Coverage

A Covered Person who wishes to appeal an adverse determination of his or her Creditable Coverage by the Plan may appeal the determination by following the procedures in the provision entitled "Benefit Claim Procedures and Appeal Procedures for Claims" in the General Information section of the Plan. In such instances, an appeal of an adverse determination of Creditable Coverage will be handled in the same manner as if the adverse determination was a denial of a claim for benefits under the Plan.

BASIC AND MAJOR MEDICAL BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Professional Charges

Eligible professional charges are covered as specified on the Schedule of Benefits. Specialty professional charges described elsewhere in the plan are processed under such specialty provider.

Surgical Services

Eligible charges are covered for surgery when performed in a Hospital, outpatient department of a Hospital, ambulatory surgical center or clinic. Benefits payable for covered bilateral surgical procedures done at the same setting are limited to a maximum of one and one-half the charge for the single surgical procedure. Eligible charges include hospital pre-operative and post-operative care. Eligible charges for surgical services include, for example, the following:

1. cosmetic surgery required as a result of an accidental injury;
2. functional repair or restoration of any body part when necessary to achieve normal body function;
3. charges for an assistant surgeon;
4. charges for an elective sterilization for a covered employee or covered dependent spouse; and
5. abortion procedures for a covered employee or covered dependent when the life of the mother would be endangered if the fetus were carried to term or when the mother has been diagnosed with a nervous or mental disorder.

Podiatry Services

Eligible charges are covered for the following podiatry services:

1. exostosectomy, limited to the bones of the feet;
2. correction of hammer toes;
3. removal of benign skin growths of the feet;
4. partial removal of ingrown toenails and root with plastic surgery;
5. complete removal of toenail with or without matrix;
6. care of fractures of bones of feet;
7. incision and drainage of infected area of feet;
8. palliative reduction or paring;
9. arthroplasty, limited to the bones of the feet; and
10. bunionectomy.

Oral Surgery

Eligible charges are covered for the following oral surgical procedures:

1. surgical extraction of impacted, unerupted teeth;
2. excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedure to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. apicoectomy (excision of the apex of the tooth root);
5. excision of exostosis of the jaw and hard palate;
6. incision and drainage of cellulitis (tissue inflammation) of the mouth;
7. incision of accessory sinuses, salivary glands, or ducts;
8. reduction of dislocations and excision of the temporomandibular joints;
9. apicoectomy - excision of apex of tooth root;
10. gingivectomy - excision of loose gum tissue to eliminate infection;
11. osteotomies;
12. frenectomy (incision of the membrane connecting the tongue to the roof of the mouth); and
13. osseous surgery.

Anesthesia

Eligible charges are covered for anesthesia and its administration when rendered by a provider who is licensed to perform these services.

Maternity Charges

Eligible charges are covered for medical care in connection with pregnancy, childbirth or a related medical condition of a covered employee or covered dependent.

Newborn Coverage

Eligible charges for inpatient care of a newborn infant of the covered employee or covered dependent include, for example, the following:

1. Hospital nursery room, board and care;
2. necessary x-ray and laboratory services;
3. physician's visits;
4. charges for circumcision;
5. treatment for premature birth; and
6. necessary surgery to repair or restore a body part to achieve normal function.

Education and Training Services

Eligible charges for education and training services are covered when such training is for a medical condition for which the education and training is appropriate and is in conjunction with other health care services provided by the hospital for that medical condition such as with a surgery or inpatient hospitalization. Also allowable under this benefit are pharmacy charges for counseling, training, and education for treatment of diabetes.

Hospital and Specialty Hospital Room and Board

Eligible Hospital charges are those incurred for semi-private rooms, wards, intensive care and coronary care units. Eligible charges for a private room are limited to the average semi-private room rate for the facility where confined. When the facility has private rooms only or a private room is medically necessary, the private room rate will be considered.

Hospital Miscellaneous Charges

Eligible charges are covered for medically necessary services and supplies which are provided while Hospital confined. Eligible charges are covered for visits made by a physician or medical specialist while confined in a Hospital or skilled nursing facility. Personal items which are not medically necessary are not covered.

Outpatient Facility Services

If a Covered Person receives care in the outpatient department of a Hospital, clinic or in an approved ambulatory surgical center, eligible charges for outpatient services include, for example, the following:

1. surgery;
2. treatment of an accidental injury;
3. treatment of a condition requiring medical care;
4. radiation, x-ray and chemotherapy; and
5. pre-admission testing.

Human Organ and Tissue Transplant

Eligible charges are covered for human organ and tissue transplants if the transplant procedure is not Experimental or Investigational. When a donor or recipient is involved, charges are covered as follows:

1. when both the recipient and the donor are covered by the Plan, each is entitled to benefits under the Plan;
2. when only the recipient is covered by the Plan, the Covered Person who is the recipient is entitled to the benefits under the Plan and the donor is entitled to certain limited benefits as specified by the Plan. In this instance, for the donor, only those eligible charges for services to donate the human organ or tissue will be covered. The donor will be eligible for these specified benefits under the Plan only if such charges are not covered for the donor from any other source, including for example, any

BASIC AND MAJOR MEDICAL BENEFITS

insurance coverage, employee benefit plan or government program. Eligible donor charges covered by the Plan will accumulate toward any maximum applicable to the Covered Person who is the recipient; or

3. when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan, however, any other source of coverage available to the donor will be considered the primary payor of benefits and this Plan will be the secondary payor of benefits. No benefits are provided to the non-covered transplant recipient.

Eligible charges related to an organ or tissue transplant include for example Hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility and those related to the evaluation and/or procurement of the organ or tissue. Benefits will not be duplicated if they are available from another plan, an organization or Medicare.

General Provisions

Early pre-certification to Health Care Management must be made as soon as the covered person is identified as a potential transplant candidate. Once enrolled in the program, a transplant facilitator will be assigned and will coordinate the cost savings with the covered person and physician from hospital selection, to travel arrangements, to prescription drug options. Health Care Management will contact the covered person's referring physician for additional information. Information about the program will be forwarded to the covered person regarding eligible facilities and other relevant information. The transplant facilitator will work with the covered person and his or her physician to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

Skilled Nursing Facility

Eligible charges for care rendered in a licensed skilled nursing facility are covered as specified on the Schedule of Benefits. The Covered Person must enter a licensed skilled nursing facility within 24-hours after discharge from a Hospital confinement or a related confinement in a skilled nursing facility. Care must be medically necessary as certified by the attending physician every seven days and must be for the same condition as treated in the Hospital or previous skilled nursing facility. The daily rate will not exceed the rate established for such care by the Department of Health and Human Services.

Equipment and Treatment of Diabetes

Eligible charges for the equipment and treatment of diabetes is covered under the Plan unless otherwise specified under the Prescription Drug program.

Home Health Care

Eligible charges for home health care are covered as specified on the Schedule of Benefits and are those charged by a home health care agency for:

1. evaluation of the need for, and development of, a plan by a registered nurse or medical social worker when approved or requested by the attending physician;
2. part-time or intermittent home nursing care rendered by or under the supervision of, a registered nurse;

BASIC AND MAJOR MEDICAL BENEFITS

3. part-time or intermittent services of home health aides which are:
 - (a) medically necessary as part of the home health care plan;
 - (b) under the supervision of a registered nurse or medical social worker; and
 - (c) which consist solely of caring for the Covered Person;
4. physical, respiratory, occupational and speech therapy;
5. medical supplies, drugs and medicines prescribed by the attending physician, if necessary under the home health care plan, but only to the extent such items would have been provided under the Plan had the Covered Person been hospitalized; and
6. nutritional counseling provided by, or under the supervision of, a registered dietitian when the services are medically necessary as part of the home health care plan.

Each visit by a provider of home health care of four hours or less is considered one visit.

Limitations

Home health care services do not include:

1. services or supplies not included in the home health care plan;
2. services of a family member;
3. custodial care;
4. food, housing, homemaker services or home delivered meals; or
5. transportation services.

Hospice Care

If a physician certifies that a Covered Person is terminally ill, eligible charges for Medicare certified hospice care are covered. Hospice care emphasizes the management of pain and other symptoms associated with terminal illness.

Inpatient, Outpatient and Transitional Treatment of Mental Health and Substance Abuse

Eligible charges for inpatient, outpatient and transitional treatment for Mental Health and Substance Abuse are covered as specified on the Schedule of Benefits. Treatment must be rendered in a facility approved or licensed in the state in which it is located.

Outpatient services include partial hospitalization privileges and collateral interviews with the family of the Covered Person receiving treatment. Treatment must be related to the diagnosed condition.

A transitional treatment program is a non-residential program which provides case management, counseling, medical care and psychotherapy on a regular basis for a scheduled part of a day and a scheduled number of days per week. In a transitional treatment program, services are rendered in a less restrictive manner than inpatient services but in a more intensive manner than are outpatient services.

Supplemental Accident Benefit

Eligible charges are covered as specified on the Schedule of Benefits when incurred as a result of an accidental injury.

Chiropractic Care

Eligible charges for chiropractic care including x-rays, manipulations and supportive care are covered as specified on the Schedule of Benefits. Supportive care means treatment which is medically necessary to prevent the Covered Person's condition from significantly deteriorating. Maintenance care is routine and is not medically necessary for treatment of a condition. Maintenance care is not covered by the Plan.

Therapy

Eligible charges for physical, speech, respiratory, and occupational therapy are covered as specified on the Schedule of Benefits. Speech therapy is covered only when the therapy is medically necessary due to an accidental injury, surgery or organic pathological disorder such as a stroke.

Ambulance

Eligible charges are covered for local professional ambulance service are covered as specified on the Schedule of Benefits. Transportation must be to the nearest Hospital qualified to provide treatment for the injury or illness. If the injury or illness requires special treatment which is not available in a local Hospital, transportation to the nearest Hospital equipped to provide treatment is covered.

Temporomandibular Joint Dysfunction

Eligible non-surgical treatment, services, and supplies other than oral surgical services for a covered person's temporomandibular joint dysfunction. Such medical treatment, services, or supplies must not permanently alter the teeth or bite and include: history, exam and diagnosis; diagnostic services including x-rays, magnetic resonance imaging (MRI) and computed tomography scan (CT) scans; splinting and adjustments, including muscle relaxation appliances, anterior repositioning appliances, and pivotal appliances; rental of or at the claims administrator's option purchase of a transcutaneous nerve stimulation (TENS unit), biofeedback, and physical therapy. Corrective splints are limited as specified on the Schedule of Benefits.

Other Covered Treatment, Services and Supplies

1. examinations when rendered for the diagnosis and treatment of an illness or injury;
2. routine examinations, immunizations, laboratory, and x-ray charges other than those listed in the Basic Benefits section;
3. diagnostic x-ray, laboratory, and related radiology and pathology services when rendered for the diagnosis and treatment of an illness or injury;
4. special duty nursing when medically necessary;
5. outpatient cardiac rehabilitation allowable for covered persons with a recent history of 1) heart attack, 2) coronary bypass surgery, 3) onset of angina pectoris, 4) onset of unstable angina, 5) onset of decubital angina, 6) heart valve surgery, 7) percutaneous

BASIC AND MAJOR MEDICAL BENEFITS

- transluminal angioplasty, or 8) another condition for which cardiac rehabilitation is necessitated by medical condition. No benefits are payable for behavioral or vocational counseling;
- 6.** blood or blood plasma, other than the Covered Person's or that which has been donated specifically for the Covered Person;
 - 7.** prescription contraceptive devices including subdermal implants, injections, diaphragms, and related services. IUDs are covered under the basic level as specified on the Schedule of Benefit;
 - 8.** food supplements when such are used as the sole nutrition;
 - 9.** initial purchase of prosthetic devices and supplies, including artificial limbs or eyes which replace an absent or malfunctioning body part or organ. Replacements thereof are covered if approved by Health Care Management. Repairs are covered when needed to restore proper function;
 - 10.** casts, splints, trusses, orthopedic braces, orthopedic shoes, and crutches;
 - 11.** dental services limited to the extraction of seven or more natural teeth upon recommendation of a physician provided such extraction occurs within 90 days of such recommendation and initial replacement of natural teeth provided such dental services are the result of an injury and further provided that such dental services commence within 90 days of such injury;
 - 12.** special supplies when prescribed by the attending physician such as:
 - catheters;
 - colostomy bags, rings and belts;
 - flotation pads; and
 - one insulin infusion pump each calendar year if the Covered Person has used that pump for a minimum of 30 days;
 - 13.** rental (not to exceed purchase price) or purchase of durable medical equipment, such as wheelchairs, Hospital-type beds, iron lung, oxygen equipment (including oxygen) and other durable medical equipment. Durable medical equipment is equipment which:
 - can withstand repeated use;
 - is primarily and customarily used to serve a medical purpose; and
 - generally is not useful to a Covered Person in the absence of an illness or injury.

Eligible charges for medical equipment which is prescribed by a physician will be covered while the Covered Person is receiving medical care. Eligible charges are limited to the least expensive item which is adequate for the Covered Person's needs. Repairs are covered when needed to restore proper function;
 - 14.** the first purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery;

BASIC AND MAJOR MEDICAL BENEFITS

- 15.** services and supplies which are cosmetic and are required as a result of an accidental injury. Treatment needed to achieve bodily function is covered;
- 16.** injections of medication related to a covered illness or injury;
- 17.** charges to establish an initial diagnosis of infertility;
- 18.** custom molded orthotics or orthopedic shoes;
- 19.** hospital, surgical and other necessary medical charges, including rental of kidney dialysis equipment incurred for kidney dialysis treatment, limited as specified on the Schedule of Benefits;
- 20.** eligible charges are covered for services provided by a hospital or ambulatory surgical center and for anesthesia charges provided in conjunction with dental care if any of the following apply:
 - a)** the covered person is under age five;
 - b)** the covered person has a medical condition that requires hospitalization or general anesthesia for dental care; or
 - c)** the covered person has a chronic disability which meet all of the following conditions:
 - it is attributable to mental or physical impairment or combination of mental and physical impairments;
 - it is likely to continue indefinitely; and
 - it results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency.
- 21.** nutrition counseling and educational therapy for a participant who is morbidly obese when pre-approval is received;
- 22.** charges for a voluntary second surgical opinion;
- 23.** cochlear implants, when deemed to be medically necessary;
- 24.** refractions when rendered for the diagnosis and treatment of an illness or injury; and
- 25.** charges for and related to a mastectomy, including:
 - a)** reconstruction of the breast on which the mastectomy has been performed;
 - b)** surgery and reconstruction of the other breast to produce a symmetrical appearance when performed in connection with a mastectomy; and
 - c)** prosthesis and physical complications of all stages of a mastectomy, including lymphedemas.

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

The following charges are not covered by the Plan. No medical benefits will be paid with respect to them, except as specified:

1. those due to an illness or injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
2. claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not;
3. charges or expenses for which the Covered Person (or the Covered Person's parent or guardian in the instance of a minor dependent) is not legally bound or obligated to pay or which are for medical care furnished without charge, paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government. This limitation will not apply where specifically prohibited by applicable statute;
4. those made by a Veteran's Administration Hospital or a Hospital operated by one of the Uniformed Services for a service related condition;
5. those made by a person, Hospital, or entity normally making no charge for medical care, regardless of the patient's financial ability, if the patient has no insurance for medical care. This limitation will not apply where specifically prohibited by applicable statutes;
6. those made for routine eye care, eyeglasses, contact lenses, routine hearing checks, hearing aids or charges for the fitting of eyeglasses, contact lenses or hearing aids, other than the initial purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery;
7. those made for personal comfort items including television and telephone;
8. charges for routine examinations, routine immunizations, routine x-ray and laboratory services and well-baby care, unless otherwise specified by the Plan;
9. charges for dental services, unless otherwise specified by the Plan;
10. charges in excess of the "Usual and Customary" fee as specified in the General Terms and Definitions and General Information sections of the Plan;
11. charges for services not medically necessary for diagnosis and treatment of an illness or injury;
12. services, supplies, human organ and tissue transplants, prescription drugs or medications which are Experimental or Investigational, unless otherwise specified by the Plan;
13. travel for health;
14. custodial care, rest cures, housekeeping, shopping, or meal preparation services;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

15. treatment of an illness or injury resulting from the commission of, or attempt to commit by the Covered Person, a felony or aggravated battery, unless the injury or illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition);
16. charges in connection with cosmetic surgery or treatment, except those charges related to an accidental injury, to repair a defect caused by a congenital anomaly causing a functional impairment of a dependent child, or as a result of an illness or as a result of a mastectomy or charges for functional repair or restoration of any body part when necessary to achieve normal body function;
17. Retin-A, Monoxidil, Rogaine, or their medical equivalent in the topical form, unless medically necessary;
18. personal hygiene and convenience items;
19. charges incurred before the effective date or after the termination date of coverage;
20. health care services provided while held, detained or imprisoned in a local, state, or federal penal or correctional institution or while in the custody of law-enforcement officials, unless otherwise specified by the Plan (s. 609-65, WI statutes). Persons on work release are not considered to be held, detained or imprisoned if they are otherwise eligible covered persons;
21. failure to keep a scheduled visit, phone consultations, completion of claim forms or return to work or school forms;
22. services rendered by a family member or anyone else living with her or him;
23. purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts;
24. motor vehicles, lifts for wheelchairs and scooters and stair lifts;
25. treatment of infertility and fertility enhancements, including in vitro fertilization, artificial insemination or any other artificial means of conception, transsexual surgery or treatment, and treatment of sexual dysfunction not related to organic disease. Procedures designed to reverse elective or medically necessary sterilizations are not covered;
26. Follicle-stimulating hormone (FSH), activity medications, or ovulatory stimulant medications including Menotropins, Chorionic Gonadotropins, Urofollitropins and Clomiphene Citrate;
27. charges made by a Hospital for a private room, unless otherwise specified by the Plan;
28. charges for smoking cessation, including deterrents;
29. charges for treatment of Temporomandibular Joint Dysfunction (TMJ), unless otherwise specified by the Plan;
30. oral surgery, unless otherwise specified by the Plan;
31. cochlear implants and all related health care to the implants, unless otherwise specified by the Plan;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

32. charges for a grandchild of the employee unless the grandchild meets the definition of a dependent specified in the Plan;
33. charges in excess of any maximum benefit amounts specified on the Schedule of Benefits;
34. services received from a dental or medical department, maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;
35. charges for room, board, and general nursing care for Hospital admissions, mainly for physical therapy or for diagnostic studies;
36. charges for treatment to induce weight loss, unless it is determined to be medically necessary for treatment of morbid obesity;
37. charges for a pre-existing condition, as specified by the Plan;
38. charges for an abortion, except when the life of the mother would be endangered if the fetus were carried to term;
39. contraceptive medications and devices, unless otherwise specified by the Plan;
40. massage therapy;
41. wigs, prosthetic hair pieces, hair transplants, or hair implants;
42. health education, marriage counseling, holistic medicine, or other programs with an objective to provide complete personal fulfillment;
43. vision therapy;
44. charges which are reimbursable through medical coverage provided by or available through:
 - any applicable "No-Fault" automobile law or coverage;
 - any automobile, homeowners, aircraft, boat owners or similar policy of insurance;
or
 - any medical insurance policy issued to a student by or through a school or university or college;
45. charges for prescription drugs, medications or supplies except those which are administered in or dispensed at a physician's office, a Hospital, skilled nursing facility or other inpatient setting;
46. maintenance care;
47. charges by a provider or facility for Pre-admission Certification or Concurrent Stay Review;
48. charges over the Usual and Customary as determined by Anthem for medical records fees;
49. charges for third party examinations and treatments, such as those requested for employment, purchase of insurance or school;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

- 50.** charges for examinations and all related services which are performed pursuant to state statute or regulation, unless the injury or illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition);
- 51.** charges incurred for private duty nursing services, other than those performed for home health care services, unless otherwise specified by the Plan;
- 52.** charges for recreational therapy, vocational training or therapy, educational training or therapy, physical fitness, or exercise programs, unless otherwise specified by the Plan;
- 53.** indirect services provided by a health care provider for services including creation of laboratory standards, procedures, and protocols, calibrating equipment, supervising the testing, setting up parameters or test results and reviewing quality assurance data;
- 54.** dental repair of a participant's sound natural teeth due to an accident caused by chewing resulting in damage to a participant's sound natural teeth;
- 55.** charges for acupuncture;
- 56.** charges or taxes legally imposed by a governmental entity including those calculated on the amount of eligible charges paid for a Covered Person under the Plan;
- 57.** a response for information may be required by the Plan in order to process claims (other than for subrogation purposes, i.e. other insurance and full-time student eligibility updates). The Plan has the right to deny claims submitted for benefit payment if such information is not received. (Please contact the Third Party Administrator if you have questions regarding the required information);
- 58.** health care services provided a) in the examination, treatment, or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet which are billed as routine and not associated with a medical diagnosis, b) in the cutting or trimming of toenails which are billed as routine or associated with a medical diagnosis except for the medical diagnosis of diabetes, or c) in the non-operative partial removal of toenails which are billed as routine or not associated with a medical diagnosis;
- 59.** treatment of weak, strained, flat, unstable or unbalanced feet, chronic foot strain or symptomatic complaints of the feet;
- 60.** charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs;
- 61.** food received on an outpatient basis, vitamins or food supplements unless otherwise specified by the Plan;
- 62.** room, board, services, and supplies that are furnished to a covered person by a hospital on the Friday and Saturday of the weekend of the hospital admission if the covered person is admitted as a registered resident patient to the hospital on one of those days, unless the participant's hospital admission is medically necessary or such admission is required to provide the participant with emergency medical care of a covered illness or injury;
- 63.** medications, drugs, or hormones to stimulate human biological growth unless there is a laboratory-confirmed physician's diagnosis of the covered person's growth hormone deficiency;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

64. sleep therapy or services provided in a premenstrual syndrome clinic or holistic medicine clinic;
65. therapy and testing for treatment of allergies including services related to clinical ecology, environmental allergy, allergic immune system dysregulation, sublingual antigens, extracts, neutralization tests and or treatment unless such therapy or testing is approved by the American Academy of Allergy and Immunology of the US Department of Health and Human Services or any of its offices or agencies;
66. genetic testing including tests using DNA to determine presence of a genetic disease or disorder;
67. not a covered expense under the Plan;
68. charges for services not provided by a Physician/Provider are not covered under the Plan;
69. prosthetic devices and durable medical equipment which do not meet the requirements of items 1 through 4 in the definition "Medically Necessary" in the General Terms and Definitions section of the Plan; and
70. charges for services from providers who have been flagged in the BlueCard system for potential billing irregularities.

PRESCRIPTION DRUG BENEFITS

Navitus Health Solutions will administer the Prescription Drug Plan. All prescription drug claims should be submitted directly to Navitus for reimbursement.

Under this benefit, the Covered Person is responsible for the co-payment as specified on the Schedule of Benefits. After satisfaction of the listed co-payment, eligible charges are covered at 100%.

Eligible prescription drugs are as follows:

- 1.** legend drugs and biologicals that are FDA approved which by law require a written prescription, are prescribed for treatment of a diagnosed illness or injury, and are purchased from a PBM Network Pharmacy after a coinsurance amount as described in the Schedule of Benefits;
- 2.** compounded medication of which at least one ingredient is a prescription legend drug;
- 3.** insulin, dispensed in a maximum quantity of a 30 consecutive day-supply for one prescription drug;
- 4.** therapeutic devices or appliances;
- 5.** self-injectables;
- 6.** diaphragms, cervical caps, oral contraceptives;
- 7.** Tretinoin (Retin-A) through age 34, thereafter prior authorization is required;
- 8.** Adapalene (Differin) through age 34, thereafter prior authorization is required; and
- 9.** legend and non-legend Meclizine on prescription.

The prescription drug benefit applies if the Covered Person has the prescription filled by a participating pharmacy. If the Covered Person is unable to locate a participating pharmacy, the prescription should be submitted directly to Navitus Health Solutions at the following address:

**Navitus Health Solutions
5 Innovation Court
Appleton, WI 54914
1-866-333-2757**

LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION DRUG BENEFITS

The following charges are not covered and no benefit will be paid with respect to them, except as noted:

- 1.** any prescription dispensed prior to the Covered Person's effective date or after the termination date of coverage;
- 2.** charges for the administration or injection of any drug;
- 3.** refills of covered drugs which exceed the number that the prescription order specifies or refills of covered drugs after one year from the date of the original prescription;
- 4.** charges for spilled, stolen, or lost prescription drugs;
- 5.** covered prescription drugs which are not customarily charged for, or for which the provider's charge is less than the required co-payment;
- 6.** claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not;
- 7.** charges furnished or covered by, or on behalf of, the United States, or any state, province, or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance;
- 8.** charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage;
- 9.** covered prescription drugs or medicines covered by Medicare, if you are covered by or are eligible to be covered by either, Part A or B of Medicare, but only to the extent benefits are, or would be, available if you had applied for Medicare;
- 10.** charges incurred due to an illness or injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
- 11.** prescription drugs or medications which are Experimental or Investigational;
- 12.** prescription drugs or medicines in connection with sex transformation surgery, including sex hormones related to such surgery and prescription drugs or medicines in connection with treatment of sexual dysfunction not related to organic disease;
- 13.** prescription drugs or medicines for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins);
- 14.** the Coordination of Benefits provision specified in the Plan does not apply to the Prescription Drug Benefit. (The Prescription Drug Plan will be the primary payor of benefits);
- 15.** non-legend drugs, other than Insulin and Meclizine;
- 16.** topical hair growth preparations, whether commercially prepared or compounded;

LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION DRUG BENEFITS

17. all drugs which are not self-administered or are administered in a Hospital, long-term care facility or other inpatient setting;
18. charges for supplies and medicines purchased from a Non-network pharmacy, except when emergency or urgent care is required;
19. charges for medications obtained through a discount program or over the internet, unless prior authorization is received;
20. implantable contraceptives such as Norplant, regardless of intended use; and
21. human growth hormones.

COORDINATION OF BENEFITS

The Coordination of Benefits section is intended to determine which plan provides benefits when there are two or more plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, “Plan” means any plan providing medical or dental benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile “no-fault” and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; and (l) this Plan.

The term “Plan” is construed separately with respect to each Plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such Plan, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

“**Allowable Expense**” means any Usual and Customary fee, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

“**Claim Determination Period**” means calendar year, except that if in any calendar year the person is not covered under the Plan for the full calendar year, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

“**Claim**” means a request that benefits of a Plan be provided or paid.

“**Primary Plan**” means a Plan whose benefits are determined without regard to any other Plan.

“**Secondary Plan**” means a plan which is not a primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another Plan and may be reduced because of the other Plan's benefits.

For purposes of this Coordination of Benefits section, “This Plan” means the **City of Milwaukee** Medical and Prescription Drug Plan.

Effect on Benefits

Maintenance of Benefits: when a claim is made, the Primary Plan pays its benefits without regard to any other Plan. The Secondary Plan adjusts its benefits so that the total benefits available do not exceed the Allowable Expense. No Plan pays more than it would without the coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other Plan does not have Coordination of Benefits, that Plan pays first.
2. The benefits of a Plan which covers the person as an employee, member, or subscriber (other than as a dependent) are determined before the benefits of a Plan which covers the person as a dependent.
3. **Birthday Rule:** the benefits of a Plan which covers the person as a dependent are determined according to which parent's birthdate occurs first in a calendar year (day and month). If the birth dates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined first. If the other Plan does not contain the birthday rule but has a rule which coordinates benefits based on gender and the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the Order of Benefits.

If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

- when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be the Primary Plan;
 - when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody are determined before the benefits of the Plan which covers that child as a dependent of the stepparent. In addition, the benefits of a Plan which covers that child as a dependent of the stepparent are determined before the benefits of a Plan which covers that child as a dependent of the parent without custody; and
 - notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other Plan which covers the child as a dependent child.
4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a Plan which covers the person as a laid-off or retired employee, or as a dependent of such person, are determined after the benefits of a Plan which covers such person through his or her own present employment or through the present employment of another person.

COORDINATION OF BENEFITS

5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a Plan which has covered the person for the longer period of time are determined before the benefits of a Plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the Covered Person's consent, will release to, or obtain from, any insurance company, organization or person, information needed to implement this provision. The Covered Person shall agree to furnish any information required to apply these provisions.

Coordination of Benefits With Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If the Covered Person is eligible for Medicare Benefits, but not necessarily enrolled, the benefits under this Plan will be coordinated to the extent benefits would have been payable under Medicare, as allowed by Federal Statutes and Regulations.

Facility of Payment

Payment made under any other Plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

Coordination Under the BlueCard Program

Benefits processed under the BlueCard program may be paid prior to determining the Plan's liability for any claim(s). If it is determined that this Plan is the Secondary Plan, then this Plan shall have the right to recover the expenses paid in excess of this Plan's liability as the Secondary Plan. The participant may be required to furnish information and to take such other action as is necessary to assure the rights of this Plan.

HOW TO FILE A CLAIM

The covered employee and covered spouse will receive a group benefits identification card. It will provide information such as the employee's name, group name and group number.

If a network provider is utilized, the network provider will file an itemized claim for you and payment will be made directly to the provider.

Whenever a covered person accesses health care services outside the network area, an itemized claim for those services may be filed by the provider and payment will generally be made directly to the provider, however, the host or local plan directs Anthem on whether the claim can be paid directly to the provider, or if payment should be directed to you. Anthem cannot override their direction.

If claim submission is not offered by the provider of service, then the covered person should refer to their identification card regarding the network(s) listed and ask the provider of service for the address of the network location for which the itemized claim can be submitted for processing. If the provider of service can not provide the network location address, then the covered person should contact the employer for network address information. Payment will be made directly to the provider, and only to the employee if proof of full payment is submitted, however, as noted above, if a claim is incurred outside the network area, the host or local plan directs Anthem on whether the claim can be paid directly to the provider, or if payment should be directed to you. Anthem cannot override this direction. The covered person should not submit the provider's claim directly to Anthem.

The covered person may choose any provider of service. There is no restriction on the selection of a provider as long as the provider of service meets the definitions contained in the Plan. Benefits are payable directly to the provider of service and only to the employee if proof of full payment is submitted, subject to the host or local plan direction noted above. If Anthem needs more information to process a claim, the covered person or the host or local plan will be contacted. Anthem is prohibited (by Blue Cross Blue Shield Association rules), from contacting the provider of service directly.

An "itemized claim" must be submitted when filing a claim. An "itemized claim" is one which shows:

1. Employee's name, address and identification number.
2. Dependent's name, if the claim is on a dependent.
3. Employer's name.
4. Name and address of the provider of service.
5. Diagnosis.
6. Itemization of charges.
7. Date the illness or injury began or the date treatment started.

HOW TO FILE A CLAIM

Canceled checks, cash register receipts or personally prepared claims are not accepted in lieu of itemized claims from providers of service.

If benefits are subject to the Coordination of Benefits provision, whereby another plan is required to pay benefits first, a copy of the other plan's Explanation of Benefits should be sent to Anthem. This can be done either when initially submitting the claim or as soon as possible thereafter. This procedure will expedite the processing of claims subject to the Coordination of Benefits provision.

GENERAL TERMS AND DEFINITIONS

“ACTIVELY AT WORK” means that the employee is at work and performing the regular duties of the employee's position for the employer.

An employee is considered to be actively at work for the employer on: (a) each day of regular paid vacation; (b) each regular non-working day, provided in each instance that the employee was actively at work on the last regular work day preceding the absence; (c) any day an employee is covered under the Plan by virtue of a leave as described in the Plan (other than an FMLA leave); (d) any day an employee is on an FMLA leave; or (e) for purposes of the waiting period to obtain coverage under the Plan as specified in the “Effective Date of Coverage” provision in the Effective Date of Coverage section of the Plan, any day on which an employee is absent from employment with the employer due to a health factor of the employee.

“AMBULATORY SURGICAL CENTER” means a licensed facility that provides general surgery and meets all of the following requirements:

1. is directed by a staff of physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period;
2. has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period;
3. extends surgical staff privileges to physicians who practice surgery;
4. has at least two operating rooms and one recovery room;
5. provides, or coordinates with a medical facility in the area for, diagnostic x-ray and laboratory services needed in connection with surgery;
6. provides in the operating and recovery rooms full-time skilled nursing services directed by a registered nurse; and
7. is equipped and has trained staff to handle medical emergencies. It must have a: (a) physician trained in cardiopulmonary resuscitation; (b) defibrillator; (c) tracheotomy set; and (d) blood volume expander.

“CALENDAR YEAR” means the period from January 1 through December 31 of the same year.

“CONFINEMENT” means the period of time in which a Covered Person is registered as an inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

GENERAL TERMS AND DEFINITIONS

“COVERED PERSON” means a person meeting the eligibility requirements for coverage as specified in the Plan, who has satisfied any applicable waiting period and who is properly enrolled in the Plan.

“CUSTODIAL CARE” means care designed to help a person in the activities of daily living, and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision of medication that can be self-administered and assistance in getting in or out of bed, walking, bathing, dressing and eating.

“BLUECARD PROGRAM” means the national program comprised of Blue Cross and Blue Shield Plans which allow a covered person to receive covered services from providers who have a contract or agreement with another Blue Cross and/or Blue Shield Plan located outside the geographical area served by Anthem. The local Blue Cross and/or Blue Shield Plan which services the geographical area where the covered service is provided is referred to as the Host Blue Cross and/or Blue Shield Plan.

“DEPENDENT” means a person as defined by the employer for the duration specified by the employer.

“EFFECTIVE DATE OF COVERAGE” means the date on which coverage under the Plan begins for a Covered Person, provided application for coverage was made when eligible for coverage under the Plan.

“EFFECTIVE DATE OF THE PLAN” means January 1, 2005.

“EMPLOYER” means **City of Milwaukee**

“EXPERIMENTAL OR INVESTIGATIONAL” means any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
2. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis;
3. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug

GENERAL TERMS AND DEFINITIONS

or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigational shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of non-human organs, tissues, or cells.

Prescription medicine for the treatment of “HIV Infection” shall not be considered “Experimental or Investigational” if it satisfies all of the criteria listed below. “HIV Infection” means the pathological state produced by a human body in response to the presence of HIV as defined in Wisconsin Statutes section 631.90(1).

1. the prescription medication is prescribed by the covered person’s physician for the treatment of HIV Infection or an illness or medical condition arising from or related to HIV Infection; and
2. the prescription medication is approved by the Federal Food and Drug Administration for the treatment of HIV Infection or an illness or medical condition arising from or related to HIV Infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV Infection or an illness or medical condition arising from or related to HIV Infection, and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33; and
3. if the prescription medication is an investigational new drug described in (2) above and it is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

Upon receiving a request for prior authorization of an Experimental or Investigational procedure that includes all of the required information in which to make a decision, the Plan shall within 5 business days after receiving the request, issue a coverage decision. If the Plan denies coverage of an experimental or investigational treatment, procedure, drug or device for a covered person who has a terminal condition or illness, the Plan shall, as part of its coverage decision, provide the covered person with a denial letter that includes all of the following:

- a) a statement setting forth the specific medical and scientific reasons for denying coverage; and
- b) notice of the covered person’s right to appeal and a description of the Plan’s appeal procedure.

“FAMILY MEMBER” means a Covered Person's spouse, child, parent, brother, sister and any other eligible dependent as described by the Plan.

“HOME HEALTH CARE” means services or supplies rendered to, and in the home of, a Covered Person or in the home of a family member as an alternative to services and supplies provided as part of an inpatient confinement in a Hospital or skilled nursing facility.

GENERAL TERMS AND DEFINITIONS

“HOME HEALTH AIDE SERVICES” means those services which may be provided by a qualified individual, other than a registered nurse, which are medically necessary for the care and treatment of a Covered Person.

“HOME HEALTH CARE AGENCY” means an agency which: (a) is certified by the Covered Person's physician as an appropriate provider of home health aide services; (b) has a full-time administrator; (c) maintains daily clinical records of services provided to the Covered Person; (d) includes on its staff at least one registered nurse to supervise nursing care; and (e) is coordinated by a state licensed Medicare certified home health care agency or certified rehabilitation agency.

“HOME HEALTH CARE PLAN” means care and treatment of a Covered Person for an injury or illness under a plan of home care established and approved in writing by the Covered Person's attending physician. The physician must also certify that the treatment for the injury or illness would otherwise require confinement in a Hospital or a skilled nursing facility. The home health care plan must be reviewed at least every two months.

“HOSPITAL” means an institution which is duly licensed as a Hospital (to the extent such licensing is required by state or federal law) and which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and which meets all of the following requirements:

1. is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a Hospital that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;
2. provides organized facilities for laboratory, diagnostic services, medical treatment and surgery;
3. provides 24-hour nursing care by licensed registered nurses;
4. has a staff of one or more licensed physicians available at all times; and
5. in no event, however, shall the term Hospital include an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility or a home for the aged.

“ILLNESS” means pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

“INJURY” means a condition caused by accidental means and from an external force which results in damage to the Covered Person's body from an external force.

“INTENSIVE CARE UNIT OR CORONARY CARE FACILITY” means a section, ward, or wing within a Hospital, which is operated solely for critically ill patients. It provides special supplies, equipment and constant observation and care by registered nurses or other Hospital personnel.

GENERAL TERMS AND DEFINITIONS

"LATE ENROLLEE" means an individual who enrolls for coverage under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan, or
2. a special enrollment period. [See "Special Enrollment Provisions" in the Effective Date of Coverage section of the Plan.]

"MASTER PLAN DOCUMENT" means that document signed by the Plan Sponsor and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto which set forth the terms of the Plan.

"MAXIMUM BENEFIT" means the total eligible charges that the Plan will pay per Covered Person while that Covered Person is covered by the Plan.

"MEDICALLY NECESSARY OR MEDICAL NECESSITY" means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

"MEDICARE" means the program for health benefits under Title XVIII of the Social Security Act as amended.

"MENTAL HEALTH" means mental, nervous or emotional disease or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

"PHYSICIAN/PROVIDER" means any person who is validly licensed to perform services for which benefits are provided under the Plan and who is acting within the scope of that license. For purposes of Mental Health and Substance Abuse charges, "Physician/Provider" shall also include any person approved or licensed by the state in which services are rendered for treatment of such conditions.

"PLAN" means this employer's Master Plan Document and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto.

"PLAN ADMINISTRATOR" means **City of Milwaukee**

GENERAL TERMS AND DEFINITIONS

“PLAN SPONSOR” means **City of Milwaukee**

“PLAN YEAR” means the period beginning January 1 and ending December 31.

“RETIRED EMPLOYEE” means a retired employee as specified by the employer.

“SERVICE IN THE UNIFORMED SERVICES” means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

“SKILLED NURSING FACILITY” means a facility which meets the following:

1. is regularly engaged in providing skilled nursing care for sick and injured persons;
2. requires that the patient be regularly attended by a physician;
3. maintains a daily record of each patient;
4. provides 24-hour nursing care which is supervised by a registered nurse;
5. is not, except incidentally, a home for the aged, a hotel or the like;
6. is not, except incidentally, a place for the treatment of mental health and substance abuse; and
7. is licensed as a skilled nursing facility, if such licensing is required.

“SUBSTANCE ABUSE” means the use of a psychoactive substance in a manner detrimental to society or the Covered Person and which meets, or with continued use may meet, criteria for substance abuse or drug dependency.

“THIRD PARTY ADMINISTRATOR” means Blue Cross Blue Shield of Wisconsin using the trade name Anthem Blue Cross and Blue Shield (“Anthem”).

“UNIFORMED SERVICES” means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

“USUAL AND CUSTOMARY” means the following:

Allowed Amount

The amount the Third Party Administrator will reimburse for services and supplies:

- which meet the Third Party Administrator’s definition of Covered Services, as long as such services and supplies are not excluded under the Covered Person’s Plan;
- that are Medically Necessary; and
- that are provided in accordance with the Covered Person’s Plan.

GENERAL TERMS AND DEFINITIONS

The Allowed Amount is determined as follows:

- **For providers who have agreed to the reimbursement amounts for this product-**
The rate the Third Party Administrator has agreed by contract to reimburse the Provider for a given service or supply.
- **For all other providers*** –
 - Rates negotiated, or otherwise recommended, by a vendor, subcontractor or affiliate and which may have been agreed to by the Out-of-Network provider; or
 - the following, alone, or in combination:
 - the amount the Third Party Administrator pays other Providers (contracted or non-contracted);
 - an amount based on what the Centers for Medicare and Medicaid Services (CMS) pays providers for the same services or supplies.**

Reimbursement is based on the Allowed Amount for the type of service a Covered Person receives, for example, inpatient surgery versus an office visit. For certain Covered Services, you are required to pay a percentage of the Allowed Amount as a Copayment and/or Coinsurance. The Allowed Amount is subject to the Third Party Administrator's reimbursement policies. It is also subject to clinical edits which are designed to verify the care and treatment you received is clinically appropriate, meets accepted medical standards of care, and is documented in a manner that is consistent with industry accepted coding and reporting. Application of reimbursement policies and clinical edits can alter the Allowed Amount, depending on the claim for payment.

* You are responsible to pay the difference between the Allowed Amount and the amount the provider charges. Depending on the service, this difference can be substantial. To assist you in determining this amount and the amount of your Copayment and/or Coinsurance for a given claim in light of applicable reimbursement policy application or after edits are applied, you may contact Customer Service. In order to best assist you, you will need to obtain, from your provider, the specific procedure codes for the services your provider will be rendering.

**Certain medical and surgical services include work before and after the procedure, as well as other services integral to the standard medical/surgical service (for example, draping the patient, inserting a venous access device, and documentation regarding the procedure). When multiple procedures are performed on the same day, by the same individual physician or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Reimbursement at 100% for such procedures would represent duplicative payment for components of the primary procedure.

“WAITING PERIOD” means the period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of Anthem as Third Party Administrator. Anthem provides administrative claim payment services only and does not assume any financial risk or obligation with respect to claims. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the company identified in the Plan Information section as the Agent for Service of Legal Process. The employer may delegate any of its powers or responsibilities among its employees and to such other agents as the employer deems appropriate.

Alternative Care

In addition to benefits elsewhere in this Plan, the Plan may elect to offer benefits for services, pursuant to a Plan approved alternative treatment plan for a covered person. Alternative benefits are provided at the sole discretion of the Plan, and only when and for so long as the Plan determines that the alternative services are Medically Necessary.

If the Plan elects to provide alternative benefits for a covered person in one instance, it will not obligate the Plan to provide the same or similar benefits for other covered persons in any other instance, nor will it be construed as a waiver of the Plan's right to administer this Plan thereafter in strict accordance with its express terms. Further, if the Plan elects to provide alternative benefits for a covered person, it will not obligate the Plan to provide the same benefits for the same covered person without prior approval and authorization.

Calculation of Plan Maximum Amounts

Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Clerical Error

Clerical error on the part of the Plan Administrator or Third Party Administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by the Third Party Administrator. The Covered Person agrees to reimburse the Plan for any payment made to or for the Covered Person in error.

Common Accident Deductible

If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.

Conformity With Government Law

If a provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Cost Sharing Provisions

Typically, these terms are used in the “Schedule of Benefits” section of the Plan. The Plan may use one or more of these terms.

“Deductible” generally means an amount which is reduced from eligible charges before benefits of the Plan are payable. It is the covered person’s responsibility to pay the deductible amount.

“Coinsurance” generally means the percentage of the eligible charges for covered services and supplies which the Plan will pay —subject to all of the provisions of the Plan. It is the responsibility of the covered person to pay for the percentage of coinsurance not payable by the Plan.

“Copayment” generally means a fixed amount of money that a covered person is required to pay toward the cost of a specified service or supply that is covered by the Plan.

“Non-compliance Penalty” generally means an amount that is reduced from eligible charges due to a failure to comply with specified provision requirements of the Plan. Any amount not covered by the Plan due to a non-compliance penalty is the responsibility of the covered person.

The covered person will also be responsible to pay for charges that the Plan will not cover such as those that exceed the Usual and Customary amount covered by the Plan for a service or supply, charges for amounts that relate to services or supplies that are not covered by the Plan and charges for amounts that exceed the Plan’s benefit maximums or plan maximums.

When a covered person obtains health care services through BlueCard outside the geographic area Anthem serves, the amount a covered person pays for covered services is calculated on the lower of:

- the billed charges for a covered person’s covered services; or
- the negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes onto Anthem.

Often, this “negotiated price” will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a covered person’s health care Physician/Provider or with a specific group of Physicians/Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with a covered person’s health care Physician/Provider or with a specified group of Physicians/Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount a covered person pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a covered person’s liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate a covered person’s liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, Anthem would then calculate a covered person’s liability for any covered health care services in accordance with the applicable state statute in effect at the time a covered person received his/her care.

GENERAL INFORMATION

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Master Plan Document

The Master Plan Document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan.

Medical Care Provided By The United States

The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related illness or injury. The Plan will also reimburse eligible charges for medical care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between "new" drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Participant Contribution

A Participant Contribution is the amount an employee is required to pay in order to participate in the Plan. Contact your employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage (COBRA)" will receive a separate notice which will indicate the cost to participate in the Plan.

Payments Directly To Providers

The Plan shall pay a non-BlueCard provider directly for health care services rendered by such provider to a covered person, unless otherwise specified by the employee or the Host Blue. For claims from BlueCard providers, the Plan shall pay a provider directly for health care services rendered by such provider to a covered person pursuant to Blue Cross and Blue Shield Association rules.

Payments Made Prior To Determining Final Liability

The covered person shall reimburse the Plan for any payment made by the Plan which is subsequently determined by the Plan to be in excess of the amount required to be paid by the terms of the Plan.

Physical Examination

The Plan at its expense shall have the right and opportunity to have the Covered Person examined for evaluation and verification of an illness or injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination

While the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. The Board of Directors of the Plan Sponsor either will have pre-approved or will later ratify by corporate resolution, including by general ratification, any such Plan amendment or termination of the Plan.

In the event the Plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms and conditions of the Plan. Plan assets will be allocated first to the payment of claims, and thereafter in a manner that is for the exclusive benefit of the participants, except that any taxes and administration expenses may be made from Plan assets.

Plan Interpretation

The Plan Administrator shall have all powers necessary to effectuate the provisions of the Plan. The Plan Administrator has contracted with Anthem to process claims, maintain Plan data, and perform other Plan connected services. However, the Plan Administrator shall determine all questions arising in the administration, interpretation and application of the Plan, and shall, from time to time, formulate and issue such rules and regulations as may be necessary for the purpose of administering the Plan. Any interpretation, determination, rule, regulation, or similar action or decision issued by the Plan Administrator, or any person acting at its direction, shall be conclusive and binding on all persons, except as otherwise provided herein with any such determination, rule, regulation or similar decision not being set aside by a reviewing tribunal unless it is determined by a court of competent jurisdiction that the Plan Administrator acted in an arbitrary and capricious manner. Benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between the employer and any employees or other persons or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer, or to interfere with or abridge the right of, the employer to discharge any employee at anytime.

Plan Maximums and Benefit Maximums

“Plan Maximums” generally means the total amount the Plan will pay for any Covered Person while he or she is a participant in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

GENERAL INFORMATION

“Benefit Maximums” generally means the Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an illness or injury. These limitations may also be expressed in other terms, for example, a number of days, visits or confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.

GENERAL INFORMATION

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Presumption of Receipt of Information

It shall be presumed that any information, notification or decision, provided by the Plan through the U.S. Mail, to a Covered Person or provider located in the United States is received by the Covered Person or provider within three (3) days of the date of mailing.

Preventive Services

The Plan provides information on coverage provided or excluded by the Plan for preventive health benefits or wellness benefits. This information is located in the Schedule of Benefits, Comprehensive Medical Benefits or Limitations and Exclusions of the Medical Plan sections of the Plan. As is the case with all benefits of the Plan, these services are subject to all the provisions of the Plan including, the limitation that such services not be "Experimental or Investigational".

Privacy and Security 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, including any Electronic Protected Health Information, as

defined by 45 Code of Federal Regulations (CFR) §160.103, 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 the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). 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, including implementation of reasonable and appropriate security measures to protect such Protected Health Information in accordance with 45 CFR §164.314(b)(2)(iii).
- 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.
- 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. Additionally, pursuant to 45 CFR §164.314(b)(2)(iv), the Plan Sponsor will report to the Plan any security incident of which it becomes aware, under the following conditions. If a security incident results in an actual disclosure of Protected Health Information not permitted herein, the Plan Sponsor will report such incident to the Plan. The Plan Sponsor will report to the Plan any unauthorized: (1) access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware; or (2) interference with system operations in the Plan Sponsor's

information systems, involving the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware.

- 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.
- 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.
- 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.
- 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 returned or destroyed to those purposes that make the return or destruction of the information infeasible.

4. Adequate Separation Between the Plan Sponsor and the Plan.

The following employees or classes of employees or other workforce members 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:

Director of Employee Benefits

This list includes every employee or class of employees or other workforce members 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, classes of employees or other workforce members identified above 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

GENERAL INFORMATION

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. The Plan Sponsor will ensure that access to Protected Health Information of the employees, or classes of employees identified above, is supported by reasonable and appropriate security measures, in accordance with 45 CFR §164.314(b)(2)(ii).

5. Safeguard Requirement.

Pursuant to 45 CFR §164.314(b)(2)(i), the Plan Sponsor will implement administrative, physical, and technical safeguards to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

Proof of Claim

Written proof of a claim must be submitted to the Plan by the Covered Person or the provider of service within 120 days after the date such claim is incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to provide written proof of the claim within the time required, except that no claim shall be eligible for payment if it is submitted more than one year and 120 days from the date the claim was incurred. A claim shall be considered as incurred on the date the services or supplies are rendered or received.

Rescission of Coverage

The Plan has the right to rescind coverage for which the employee or Covered Person made a material misrepresentation on his or her application for coverage form or change notice form. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the employee or a Covered Person or cover a medical condition of the employee or a Covered Person when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the employee, Covered Person or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Right of Recovery For Payments Made

The Plan reserves the right to recover payments made under the Plan in the amount by which the payments exceed the maximum amount required to be paid under the provisions of the Coordination of Benefits section, through the BlueCard program, or any other provisions of the Plan. In the discretion of the Plan Administrator, such recovery may include the reduction in the payment by the Plan of the future benefits properly payable under the Plan. This right of recovery applies against:

1. any person to whom, for whom, or with respect to whom such payments were made; or

GENERAL INFORMATION

2. any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

Rights With Respect To Medicaid

Payment of benefits with respect to a Covered Person under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a Covered Person in the Plan or in determining or making any payments for benefits of an individual as a Covered Person, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a Covered Person in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a Covered Person for payment for such supplies, services or treatments.

Self-funding

This is a self-funded Plan which means claims are paid directly by the Plan Administrator from its assets. The Plan Administrator has entered into a legal arrangement with a Third Party Administrator to assure accurate, impartial and timely payment of benefits to, and on behalf of, covered employees and their covered dependents.

Summary Plan Descriptions

The employer will issue to each covered employee or dependent, COBRA participant and retired employee (if retired employees are covered under the Plan), a Summary Plan Description which summarizes the benefits to which the Covered Person is entitled.

Usual and Customary Procedure

Anthem will cover the amount which is usually and customarily charged for that type of service. The amount in excess of the usual and customary fee may be pended for additional information. The employee will be notified on the Explanation of Benefits or by letter that Anthem is requesting additional information. Anthem will then contact the provider, which will give the provider the opportunity to supply Anthem with additional information which may explain the higher fee. This may include an operative report or medical records if signed authorization is received from the employee. If after receiving the additional information, the higher amount cannot be justified, Anthem will outline the reasons for the denial.

GENERAL INFORMATION

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any injury or illness occurring during, or arising from, the employee's course of employment.

Your Right To Appeal

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan. You have received the service.

If your claim is denied:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure the Third Party Administrator will follow will satisfy at least following minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Third Party Administrator's notice of the adverse benefit determination (denial) will include:

- the specific reason(s) for the denial
- a reference to the specific plan provision(s) on which the Third Party Administrator's determination is based
- a description of any additional material or information needed to perfect your claim
- an explanation of why the additional material or information is needed
- a description of the plan's review procedures and the time limits that apply to them
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge

For claims involving urgent/concurrent care:

- the Third Party Administrator's notice will also include a description of the applicable urgent/concurrent review process;
- the Third Party Administrator may notify you orally and then furnish a written notification no more than three calendar days later.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your

GENERAL INFORMATION

authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Third Party Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The company shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which is a panel review, independent review, or other process consistent with the Company reviewing the appeal. The time frame allowed for the company to complete its review is dependent upon the type of claim involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited review. You or your authorized representative may request it orally or in writing. All necessary information, including the Third Party Administrator's decision, can be sent between the Third Party Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Third Party Administrator at [the number shown on your identification card] and provide at least the following information:

- The identity of the claimant;
- The specific medical condition or symptom;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All requests for appeals should be submitted in writing by the Covered Person or the Covered Person's authorized representative, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals
P.O. Box 33200, Louisville, Kentucky 40233-3320

Upon request, the Third Party Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

How Your Appeal will be Decided

When the Third Party Administrator considers your appeal, the Third Party Administrator will not defer to the initial benefit determination or, for second-level appeals, to the earlier appeal determination.. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Third Party Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Third Party Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, the Third Party Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please contact your plan administrator.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

PLAN INFORMATION

EMPLOYER, PLAN ADMINISTRATOR AND NAMED FIDUCIARY:

City of Milwaukee
200 East Wells Street Room 701
Milwaukee, WI
414-286-3380

EMPLOYER IDENTIFICATION NUMBER:

39-6005532

PLAN NUMBER:

501

THE FOLLOWING COVERAGE IS INCLUDED IN THIS PLAN:

Comprehensive Medical and Prescription Drug Benefits

TYPE OF ADMINISTRATION:

Self-Funded Group Health Plan

THIRD PARTY ADMINISTRATOR:

Anthem
P.O. Box 10888
Green Bay, WI 54307-0888
(920) 497-1589

AGENT FOR SERVICE OF LEGAL PROCESS:

City of Milwaukee Medical and Prescription Drug Plan
c/o Anthem
P.O. Box 10888
Green Bay, WI 54307-0888
(920) 497-1589

COST:

The contributions necessary to finance the Plan are shared by the employer and the employee.

FINANCIAL RECORDS:

The financial records of the Plan are kept on a Plan Year basis ending on each December 31.

COLLECTIVE BARGAINING AGREEMENT:

This Plan has been established in connection with one or more Collective Bargaining Agreements. The provisions listed within the Collective Bargaining Agreement(s) are hereby incorporated to become part of the Plan. A copy of the Collective Bargaining Agreement is available with the Plan Administrator

