MEDICAL AND PRESCRIPTION DRUG PLAN

MASTER PLAN DOCUMENT

CITY OF MILWAUKEE

Medicare-Eligible Retired Employees

EFFECTIVE DATE OF THE PLAN: JANUARY 1, 2006

MANAGED CARE

Retired Employees should refer to the employer to determine if this Managed Care section is applicable.

Pre-admission Review

Non-urgent Care Admission

Pre-admission reviews the request for a hospital admission and the number of days for the hospital stay to determine whether the admission and the number of days for the hospital stay are within the guidelines of the Plan. All non-urgent care hospital admissions must be pre-certified before a hospital admission by calling the ENCOMPASS Managed Care Department at their toll-free number.

Urgent Care Admission

An *"Urgent Care"* admission is one where application of the time period for making non-urgent care determinations could either:

1. *Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or*
2. *In the opinion of a physician with knowledge of the medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care which is the subject of the claim*.

If a covered person is admitted to the hospital for an "Urgent Care" admission, as defined above, then no pre-certification is required for that admission. However, the ENCOMPASS Managed Care Department must be notified within the first business day following the "Urgent Care" admission by calling its toll-free number.

Questions regarding decisions made by Utilization Review may be directed to the ENCOMPASS Managed Care Department by calling its toll-free number.

Mothers and Newborns

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Maternity stays exceeding either the 48 hour or 96 hour period, require certification by the ENCOMPASS Managed Care Department or benefits may not be payable for the remainder of the hospital stay. Please see the "Newborns' and Mothers' Health Protection Act Notice" provision in the General Information section of the Plan.

Organ or Tissue Transplant

In addition, the covered person should contact the ENCOMPASS Pre-admission Review Department as soon as reasonably possible following the date on which the covered person's attending physician has indicated that the covered person is a potential candidate for an organ or tissue transplant or a potential donor for an organ or tissue transplant.

Concurrent Stay Review

Concurrent Stay Review occurs while the covered person is in the hospital. If the ENCOMPASS Managed Care Department is advised of the need for hospitalization for a longer period of time than that was certified by Pre-admission Review, the physician will be asked to provide the ENCOMPASS Managed Care Department with additional medical information to evaluate the need for the extended stay.

If the covered person is confined in an inpatient facility longer than originally certified by the ENCOMPASS Managed Care Department and the extended stay is not certified through the Concurrent Stay Review process, benefits may not be payable for the remainder of the hospital stay.

Medical Case Management

Medical Case Management focuses on acute or chronic conditions that result from serious or debilitating illnesses or injuries by coordinating the needs of the covered person, the family, the health care providers and the employer.

Second Surgical Opinion - ENCOMPASS Request

If a covered person is requested by the ENCOMPASS Managed Care Department to obtain a second surgical opinion for an inpatient surgical procedure, eligible charges will be covered as specified on the Schedule of Benefits. The physician giving the second opinion must not be in medical practice with the physician who first recommended surgery. Charges are covered for a third opinion if the first and second opinions differ. After obtaining a second surgical opinion, it is the covered person's decision whether or not to have the surgery, no matter what the results are from the second opinion.

IMPORTANT: The utilization of Managed Care is not a guarantee of benefits under the Plan. Charges are subject to all Plan provisions.

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 Managed Care program.

Managed Care Benefits

Second Surgical Opinion - ENCOMPASS Request

If a covered person is requested by the ENCOMPASS Managed Care Department to obtain a second surgical opinion for an inpatient surgical procedure, eligible charges for the second opinion examination and related services are covered at 100% and are not subject to the deductible amount.

Comprehensive Medical Benefits

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, wellness exams, 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. Outpatient hospital charges are limited to $10,000 per period of disability. **Additional benefits are available under the major medical 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.

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 $250,000 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 per visits. 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.

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.

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) radiology and pathology services such as pap smears and mammograms, 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.

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.

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.

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 $250,000 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 their covered 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 such employee's eligible dependents 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 or they would otherwise lose 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 entitled to 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;

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 entitled to 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 or as of the date the employee provides unequivocal notice of his/her intent not to return to work (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 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

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

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 end of 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.

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 will 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

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 by an amount not significantly less than the applicable premium, 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 ERISA, including 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 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.

(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 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:

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 cellulitus (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.

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 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.

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;
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, vision, respiratory and occupational therapy are covered as specified on the Schedule of Benefits and must be within 60 days of the date on which such treatment begins. 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

Eligible charges are covered for the following:

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 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 TCS. 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;

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; and

23. 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;

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;

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 TCS for medical records fees;

49. charges for third party examinations and treatments, such as those requested for employment, purchase of insurance or school;

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 or 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. 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;

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; or

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.

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. diabetic supplies (i.e., needles, syringes, alcohol swabs, lancets, lancing devices, and blood or urine strips);
5. therapeutic devices or appliances;
6. self-injectables;
7. diaphragms, cervical caps, oral contraceptives;
8. Tretinoin (Retin-A) through age 34, thereafter prior authorization is required;
9. Adapalene (Differin) through age 34, thereafter prior authorization is required; and
10. 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;

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;

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 birthdates 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
   - not withstanding 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.
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.

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.

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. If TCS needs more information to process a claim, the covered person or the provider of service will be contacted.

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.

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 TCS. 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.

"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.

"DEPENDENT" means a person as define 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 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 Statues 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.

"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.

"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" means that a service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider is required to diagnose or treat a covered person's illness or injury and which is, as determined by the Plan Administrator: (1) consistent with the symptoms or diagnosis and treatment of the covered person's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the covered person, physician, hospital or other health care provider; and (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the covered person and accomplishes the desired end result in the most economical manner. However, the fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply medically necessary.

"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.**

"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 **Total Claims Solution (TCS)**.

"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 fee usually and customarily accepted as payment for the same services within a geographical area in which the physician practices as determined by the Third Party Administrator.

In the case of a PPO Provider, Usual and Customary is the negotiated PPO discount rate for the service or 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 Total Claims Solution as Third Party Administrator. 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.

Appeal Procedure

Appeal Procedure for Denied Claims The appeal procedure for review of a denied claim is detailed below.

Written notice will be sent within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason for payment or nonpayment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. The covered person may contact the customer service department for more information.

If the covered person disagrees with the claim payment or denial, such covered person may file a grievance. The grievance must be in writing and provide all important information including member identification number, patient's name, the date of service, the place of service, and the reason for requesting the review.

Mail the grievance to the following address:

Blue Cross and Blue Shield of Wisconsin
Attn: Appeal Department
401 W. Michigan Street, C10
Milwaukee, WI 53203

If the covered person identifies the grievance as a "Grievance Appeal," an acknowledgement of receipt will be sent to the covered person within five business days of receipt.

The covered person may appear in person before the Grievance Committee to:

1. Present written or oral information; and
2. Submit written questions to the persons responsible for making the decision that resulted in the Grievance.

A notification will be sent indicating the time and place of the committee meeting at least seven days prior to the meeting. If services have already been provided, the Grievance Committee will make a determination regarding the covered person's claim within 30 days from the receipt for the claim. If an extension is required, the Grievance Committee will provide notice of a 30-day extension prior to the expiration of the applicable 30-day period. If the covered person has requested pre-certification, the Grievance Committee will call to notify the covered person of the decision within 15 days. If an extension is required, the Grievance Committee will provide notice of a 15-day extension prior to the expiration of the applicable 15-day period.

If the grievance involves a situation that qualifies as an expedited grievance as defined in the definitions section, the covered person may file the expedited grievance via telephone call to the Grievance Committee. The participant must provide pertinent information listed above. We will resolve the Expedited Grievance within 72 hours of receiving it.

The covered person can also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. The covered person can contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance
Complaints Department
P O Box 7873
Madison, WI 53707-7873

Or the covered person can call 1-800-236-8517 outside of Madison or 266-0103 in Madison to request a complaint form.

External Review Process

If the covered person disagrees with the outcome of the grievance, the covered person may be eligible to have the grievance reviewed by an Independent Review Organization. The Grievance Committee will send the covered person a list of approved organizations if the Grievance Committee denies the covered person's grievance. A copy can also be obtained from Customer Service or by contacting the Office of the Commissioner or Insurance. To qualify for External Review, the covered person's claim must involve one of the following:

1. An adverse determination; or
2. A determination that a treatment is Experimental/Investigational.

In either case, the treatment must cost at least $250 in order to qualify for External Review.

If the covered person wishes to pursue External Review, the covered person or the covered person's authorized representative must notify the Appeal Department in writing at the following address:

Blue Cross and Blue Shield United of Wisconsin
Attn: Appeal Department
401 W Michigan Street, C10
Milwaukee, WI 53203

The Appeal Department must receive the request within 4 months of the date that the Grievance Committee denied the covered person's grievance. When the covered person sends the request, the covered person must tell the Appeal Department which Independent Review Organization that the covered person wants to use and enclose a $25 check made payable to that organization.

Once the Appeal Department has received the covered person's request:

1. The Appeal Department will notify the Independent Review Organization and the Commissioner of Insurance within 2 days. Within 5 days the Appeal Department will send the Independent Review Organization copies of the information that the covered person submitted as part of the covered person's grievance, copies of the covered person's summary plan description, and copies of any other information the Grievance Committee relied on in the covered person's grievance.
2. The Independent Review Organization will have 5 days to review this material and request any additional information.
3. The Appeal Department will respond to any additional requests within 5 days to review this material and request any additional information.
4. Once the Independent Review Organization has received all the necessary information, it will have 30 days to render a decision.

There are certain circumstances in which the covered person may be able to skip the grievance process and proceed directly to External Review. Those circumstances are as follows:

1. Appeal Department agrees to proceed directly to External Review; or
2. The covered person's situation requires urgent care review.

If the covered person's situation requires an Urgent Care Review:

1. The Appeal Department will notify the Independent Review Organization and the Commissioner of Insurance within 1 day and send them the covered person's information.
2. The Independent Review Organization will have 2 days to review this material and request additional information. The Appeal Department will have 2 days to respond to this request.
3. Once the Independent Review Organization has all the necessary information, it will render a decision within 72 hours.

The decision of the Independent Review Organization is binding. If the Independent Review Organization overturns the Grievance Committee's decision, the Grievance Committee will refund the $25 the covered person paid when requesting the review.

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.

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, HMO 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.

No Loss - No Gain

Persons who have pre-existing conditions on the effective date of this Plan shall continue to have the prior plan's Pre-existing Condition Limitation administered, provided:

1. the covered persons were validly covered under the prior group plan on the date the plan terminated or was validly covered under the plan on the date immediately preceding the effective date of this Plan;
2. they are members of an eligible class in this Plan; and
3. they are covered under the Plan.

The Plan may give credit for deductibles, coinsurance limits and waiting periods that were met under the prior plan and applied to this calendar year, as long as the covered person supplies sufficient evidence of having satisfied those requirements.

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 provider directly for health services rendered by such provider to a covered person, unless otherwise specified by the employee.

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 Total Claims Solution 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.)

"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.)

Plan's Rights to Subrogation and Reimbursement

If a covered person incurs medical, dental, prescription drug or disability expenses for an illness or injury because of the fault, in whole or in part, of another person, that other person may be legally responsible for those medical, dental, prescription drug or disability expenses. Furthermore, a covered person or the covered person's guardian or estate may be entitled to receive money from an insurance contract for medical, dental, prescription drug or disability expenses resulting from an injury or illness. The Plan will be subrogated to all rights of recovery the covered person or the covered person's guardian or estate may have against such other person or persons and such insurance contract or contracts for medical, dental, prescription drugs or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person or the covered person's guardian or estate.

The Plan shall have the right to receive payment or repayment of those expenses referred to above from the person or persons that caused the illness or injury, any person who has legal responsibility for that person, that person's liability insurer, or any other insurer providing coverage for that person. The Plan shall also have the right to recover expenses it has paid or is obligated to pay from amounts paid for those expenses referred to above from the covered person's or his or her guardian's or estate's auto insurance including but not limited to uninsured or underinsured motorist coverage and med pay.

The Plan shall have "dollar one" recovery entitlement from any amounts **paid** and not simply from amounts received, regardless of whether the covered person or his or her guardian or estate is "made whole".

The Plan is automatically assigned the covered person's or the covered person's guardian's or estate's right of recovery against third parties (including their insurers) who are responsible in whole or in part for causing the injury or illness, to the extent of amounts the Plan has paid or is legally obligated to pay for the medical, dental, prescription drug or disability expenses of the covered person. The Plan will be entitled, but not obligated, to proceed in the name of the covered person or the covered person's guardian or estate against the person or persons responsible to repay the Plan for expenses the Plan has incurred for the covered person as

identified above, if the covered person or the covered person's guardian or estate fails to take the necessary action to recover such expenses.

The amount of the Plan's subrogation claim must be included in any litigation filed or any claim made or asserted by or for the covered person or the covered person's guardian or estate in connection with the injury or illness giving rise to the expenses referred to above including claims made against the covered person's own insurance. When the claim is settled or any amount is paid to the covered person, his or her legal representative, or guardian, or estate then the person receiving such funds must reimburse the Plan or cause the Plan to be reimbursed for medical, dental, prescription drug or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person.

The covered person or the covered person's guardian or estate shall not prejudice the Plan's rights of subrogation and reimbursement and shall sign and deliver documents to evidence or to secure those rights to the Plan. The Plan has the right to receive from the covered person or the covered person's guardian or estate, prior to the Plan's payment of claims or at any time subsequent thereto, a completed subrogation questionnaire, a reimbursement agreement and an acknowledgment of the Plan's subrogation and recovery rights signed by the covered person or the covered person's guardian or estate, or his or her authorized legal representative, on forms provided by the Plan.

The covered person, or the covered person's guardian, or estate is not authorized to obtain legal representation, to act on behalf of the Plan for recovery of any amounts paid by the Plan. Any contingent fee or retainer agreement entered into by the covered person or the covered person's guardian or estate will have no effect on the Plan's entitlement to the full amount of its subrogation claim on a "dollar one, first priority basis", regardless of any asserted offset for attorney fees or costs or other reduction unless specifically agreed to in writing by the Plan. This also applies to any other similar federal or state common law which would cause the Plan to receive less than the full amount of its claim. The concept of the "common fund doctrine" that governs the allocation of attorney's fees does not apply to this Plan or its rights to subrogation and recovery. The Plan may, at its discretion, enter into an agreement with the covered person his or her legal representative, guardian, or estate to represent its subrogation interest.
The Plan's rights as provided in this "Plan's Rights to Subrogation and Reimbursement" provision of the Plan document are created and preserved regardless of whether the covered person or the covered person's guardian or estate is "made whole", signs a reimbursement agreement, or signs an acknowledgment of the Plan's subrogation and recovery rights. The covered person, the covered person's guardian, estate, or legal representative shall make no distributions nor authorize any distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien or the expenses for medical, dental, prescription drug, or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person without the written approval of the Plan and shall not release any party or their insurer without the prior written approval of the Plan. In addition, the covered person, his or her guardian, estate, or legal representative will not withhold or intercept any amounts due the Plan from any party. Additionally, the covered person, his or her guardian, estate, or legal representative shall not instruct any party to forward amounts owed

to the Plan, to any entity other than the Plan, in the absence of a prior written agreement with the Plan or its Third Party Administrator.

The subrogation rights of the Plan shall be superior to and the Plan shall have "first priority" over any competing claims of the covered person, his or her guardian, estate, or legal representative, or any competing claims of a parent, spouse, or child of a covered person, to any designated or undesignated proceeds of a judgment, award, or insurance settlement of the claims of the covered person, or of any other person where such settlement, judgment or award relates to or arises from the circumstances giving rise to the medical, dental, prescription drug or disability expenses of the covered person that the Plan has paid or that the Plan is legally obligated to pay to or on behalf of the covered person.

A covered person also includes any dependent of the covered person where applicable.

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 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 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
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.

A separate description of the network and a listing of PPO network providers can be obtained automatically, without charge, from the employer or Third Party Administrator.

Usual and Customary Procedure

TCS 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 TCS is requesting additional information. TCS will then contact the provider, which will give the provider the opportunity to supply TCS 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, TCS will outline the reasons for the denial.

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.

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:

Total Claims Solution
P.O. Box 2790
West Bend, WI 53095-7970
1-800-376-0110

AGENT FOR SERVICE OF LEGAL PROCESS:

City of Milwaukee Medical Plan
c/o Total Claims Solution
975 Hansen Road
Green Bay, WI 54304
1-800-376-0110

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.