

<p style="text-align: center;">APPROVAL</p> <p style="text-align: center;"><i>Slw</i> </p>	<p style="text-align: center;">REQUEST FOR COUNCIL ACTION</p>	<p style="text-align: center;">MEETING DATE</p> <p style="text-align: center;">9/18/2012</p>
<p style="text-align: center;">REPORTS & RECOMMENDATIONS</p>	<p style="text-align: center;">Revised Summary Plan Description (SPD) for the Employee Health & Welfare Benefits for Non- Grandfathered Plan & Amendment #1 to the Plan</p>	<p style="text-align: center;">ITEM NUMBER</p> <p style="text-align: center;"><i>6.13.</i></p>

Attached is a revised Summary Plan Description (SPD) for the Employee Health and Welfare Benefits for Non-Grandfathered Plan and Amendment #1 to the Plan.

Revisions to the Health Plan NEED to take place in a two-step process. Approval of this SPD and the amendment is the first step. Staff has been working with our health benefits consultants and our third party administrator's legal and contract representatives for over two years. The entire plan document was last updated and adopted in full in 2003 (dated 2002). A substantial amount of coverage changes were required by what is commonly referred to as Obama-care, but, that is only a small piece of the total legislation in the last decade. There have been numerous amendments required by the various Federal and State legislation, a number of which have been re-revised by subsequent amendments. At the same time, the industry has improved language or altered standard boiler plate text and terminology over the last decade. Similarly, industry experience regarding coverage for procedures, circumstances, and definitions (that were previously addressed under broad language or classification) has developed best-practice language and clarifications to more clearly address such circumstances.

It is very important that we get an updated starting point from which to consider further plan coverage changes as may be considered for 2013 in the upcoming budget practice. Similarly, the consultants strongly advise that this clarified and updated document is essential in moving forward with getting the stop-loss coverage proposals for next year. Similarly, adopting a cleaned-up document will be beneficial to employees in better understanding their current coverage (as they won't have to slog through all of the various amendments) and in more clearly seeing the changes that may occur over time as the City considers changes that continue the migration toward a plan design that is more representative of those in the private sector.

As such, as Plan Administrator for the health and welfare benefit plan, I respectfully request your discretion and willingness to follow a two-step plan and encourage you to approve the plan document tonight in the form submitted. This is an important first step in finalizing a plan document. Within the next month or so, the document will come back to you again (the second step) for consideration of incorporating benefit changes that are anticipated by the 2013 proposed budget and for addressing a number of issues and clarifications that can continue to benefit from further updates. At that time, we can address any further detailed changes that the Aldermen want to address.

The nature of the re-drafting to more current language also restructured the document to more current industry practices. As such, providing a red-lined document against the 2002 version would simply be a futile and meaningless endeavor as whole sections have moved around. The document is vastly improved from the prior version and dozens and dozens of clarifications have been

incorporated. As an example of a clarification or update, the explanation of "Durable Medical Equipment" coverage on page 37 incorporated the following additional language: "without evidence of Medical Necessity and approval of the Plan Administrator." This new language allows us to deal with individual circumstances when looking at repair, purchase, or rental of such durable medical equipment so that the plan can get the most cost-effective solution.

Despite hundreds of hours spent on the document to date, it is not perfect. When it is brought back to you, I expect to still address certain issues that can benefit from further clarification. For example, greater consistency and clarification needs to be incorporated between the use of the terms "Covered Medical Expense," "Covered Dental Expenses," "Covered Expenses," "Allowable Expenses," "Allowable Charge," and "recognized charges." Similarly, we need to better address the coordination of benefits as it concerns the coverage of step children, and we need to now cross reference language and terminology with the recently revised Employee Handbook and Civil Service System Personnel Administrative Procedures. The upcoming revision will also incorporate the language requested by the Library Board relative to eliminating coverage for certain part-time employees.

Attached is a copy of a memo that was presented to the Personnel Committee in March of this year, which provides some further clarification and explanation. Except for item 4, related to step-child coverage and coordination of benefits, the other items are incorporated into the attached document. This document covers the more substantive changes incorporated. There may be some other non-substantial changes as well, for example it is typical of current plans to cover "surgical brassieres two per Calendar Year" for a "MEDICALLY NECESSARY mammoplasty following a MEDICALLY NECESSARY mastectomy." I do not have a complete list of each such limited change that may have occurred that more accurately reflects current levels of care provided by the typical health plan.

The SPD itself technically applies to just Police and Fire employees. It is Amendment #1 that then extends that language to Teamsters and all of the other non-represented employees, including those previously in bargaining units. The Common Council previously (December 2011) authorized extending the non-grandfathered plan benefits (related to the federal Patient Protection and Affordable Care Act) to all other covered employees. As such, Amendment #1 has to remain separate from the SPD during step 1, but we may roll it into the primary document as part of step 2.

Correcting the page numbers in the Table of Contents and any other non-substantive spelling and grammatical corrections will be completed as technical corrections.

COUNCIL ACTION REQUESTED

Motion to adopt the Summary Plan Description of the Employee Health and Welfare Benefit Non-Grandfathered Plan, with technical corrections, and Amendment #1 as presented, to direct the Director of Administration to bring further revisions prior to the end of 2012, and to authorize the Plan Administrator, within the scope of his authority and responsibility, to interpret the revised Plan language, during 2012, with consideration for prior Plan language and to use prior Plan language and coverage levels if necessary to resolve disputes or appeals.



Date: March 16, 2012
To: Personnel Committee
From: Mark W. Luberda
Director of Administration
RE: Health Plan Re-write and modifications

The City has not completed a full rewrite of its Health Plan ("the Plan") since 2003. Changes that have been made or required since that time have all been by amendment or Plan Administrator authorization. We have been working to incorporate those amendments, the recent significant federal health care requirements ("Obama Care"), clarifications, and improved health and insurance industry language and format into a revised document. It has been a massive undertaking, but it is very important for employees and for risk management that our health insurance coverage be clearly established and communicated. The vast majority of the changes are formatting and language clarifications that do not significantly alter the expected interpretations of our current language.

Beginning with January 1, 2013, the City has unilateral control over the terms and coverage of the Plan. Until that time, since they have existing contracts, Police, Fire, and Teamster employees have an expectation that there be no significant change in their benefit structure. We can, nonetheless, take action now to incorporate language that will be effective January 1, 2013.

Following are the areas where I will be proposing or incorporating language that deviates from the existing language to the extent that it provides for a different interpretation. The purpose of this memo is to identify and briefly explain each of these areas, but not to present an exhaustive argument for or against their inclusion into the Plan revision. We can talk about the merits of each proposal at the meeting and more detailed information can be collected if needed.

1. The most substantive language changes by far are those required by "Obama Care." These are, however, generally required by law and have already been approved by the Common Council and have been incorporated into the administration of the current Plan, just not directly into the language of the document itself. The rewrite will incorporate all the required sections.
2. The Plan previously restricted payments "If more than one surgery is performed during an operative session..." The language ignored the following possible exception which can occur: "except when multiple unrelated SURGICAL PROCEDURES are performed by two or more surgeons on separate operative fields, benefits will be based on the NEGOTIATED FEE or the USUAL AND CUSTOMARY fee for each surgeon's primary procedure." This exception has been added.

3. Commencing January 1, 2013, the Plan will not pay costs for a donor if the recipient is not also a covered member.

4. Coverage for step children will be clarified to address current social arrangements and provide for a more consistently manageable approach. Old language generally restricts coverage to step children "living with" the covered employee, but "living with" is not defined. Most dependents spend at least some time "living with" each parent. As such, it appears that there has not been any strict monitoring of the inclusion or exclusion of step children from coverage or the denial of primary coverage. At the same time, federal and state standards have changed and it is now required to cover certain dependents until age 26 whether or not they are living in the home. The solution, in general terms, is to incorporate clearer language that addresses the Plan acting as primary coverage for natural children of the employee and secondary coverage for step children. Where the step children have no other coverage or where required by court order or adoption, etc., the Plan will provide primary coverage. The point is not to eliminate coverage of step children, but, rather, to provide a more clear coordination of benefits and, as previously stated, a more consistently manageable approach. I also anticipate putting in place a more concerted effort by the TPA to gather the "other coverage" information for step children. If approved, this modification will be explained to employees during the first half of this year, with full implementation beginning 1/1/13. That will provide ample opportunity for employees to react and will enable everyone to go through an open enrollment period. It will comply with state and federal requirements.

5. Cochlear Implants: The current TPA does not believe our current plan would provide an adult coverage for a cochlear implant without direct authorization from the Plan Administrator because there is no clear language providing for cochlear implants. The City did, however, pay for one such surgery prior to my employment, which was approved by prior employees of the TPA under the general "Medically Necessary" provision. Most plans do not provide for such adult cochlear implants. Our plan, for example, specifically does not even provide for hearing aids, so it seems arguably inconsistent to provide for cochlear implants. One clear example showing that most plans had not and do not provide for this procedure is the new requirement under "Obama Care" that cochlear implants be covered, to a specified degree, for children under 18. As such, the re-write will specifically include only the federally required coverage for cochlear implants and will specifically exclude any other such coverage.

6. I recommend expanding our ability to cover repair or replacement of durable medical equipment on a case-by-case basis. The bottom line is that some of these covered items do wear out and the coverage needs to anticipate such reasonable wear and tear. We should have the flexibility to pursue whatever approach is most cost effective to the plan while remaining medically appropriate.

7. I anticipate incorporating language such that a doctor who is used to provide a second surgical opinion (not from the same group) may be selected to perform the procedure. The current Plan restricted that option.

One can see that in the approximately 110 page document there will be very few functional or coverage changes. Rewriting and reorganizing the document, however, may make it difficult for people to track or map language from the old plan to the new. This may cause some concern that the revised document includes other benefit changes that not have been identified. In order to ensure compliance with existing labor contracts and to alleviate such concerns, the resolution for approval will also include language that reiterates the authority set forth in the Plan for the Plan Administrator to interpret the document as needed and, further, to clearly authorize the Plan Administrator to interpret the revised Plan language, during 2012, with consideration for prior Plan language and to use prior plan language and coverage levels if necessary to resolve a dispute or appeal. This step will enable the City to move forward with clear, current Plan language while ensuring labor contract requirements are absolutely followed.

DISCLAIMER OF CLAIMS ADMINISTRATOR

We have prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your plan's fiduciaries and/or trustees, you are fully responsible for all legal issues that concern the plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this plan.

The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for The City of Franklin on or as of the day and year first below written.

By _____
The City of Franklin

Date _____

Witness _____

Date _____

SUMMARY PLAN DESCRIPTION
The City of Franklin
EMPLOYEE HEALTH AND WELFARE BENEFIT NON-GRANDFATHERED PLAN
Franklin, Wisconsin

This booklet is the Summary Plan Description. Its purpose is to summarize the provisions of the Plan that provide and/or affect payment or reimbursement. The Summary Plan Description supersedes any and all Summary Plan Descriptions issued to the COVERED PERSON by The City of Franklin.

The Plan is funded by The City of Franklin and COVERED EMPLOYEE and/or RETIRED EMPLOYEE contributions, if required. The benefits and principal provisions of the group plan are described in this booklet. They are effective only if the COVERED PERSON(s) are eligible for the coverage, become covered, and remain covered in accordance with the provisions of the group plan.

The purpose of providing a comprehensive medical plan is to protect the COVERED PERSONS from serious financial loss resulting from necessary medical care. However, we must recognize and deal with escalating costs. Being fully informed about the specific provisions of the Plan will help both the COVERED PERSON and the COMPANY maintain reasonable rates in the future. We have prepared the following pages as a general guide for COVERED PERSONS to become "good consumers" of health care. It will take a joint effort between ELIGIBLE PROVIDERS, COVERED PERSONS and us--the COMPANY--to make our Plan work, both now and in future years.

All health benefits described herein are being provided and maintained for the COVERED PERSONS and the covered dependents by The City of Franklin, hereinafter referred to as the "COMPANY" or "EMPLOYER". A third party administrator(s) as determined by the company, currently Auxiant, will process all benefit payments.

- **Please refer to the address on the ID card to determine where to send claims.**

In the event the Federal or State law and/or administrative guidelines requiring these provisions is repealed, amended, clarified, or further defined, the affected provision will revert to the provision in the Plan that was in existence immediately prior to this change or will be amended to reflect any new required benefit level which may continue to exceed benefit levels prior to the adoption of the Affordable Care Act.

Unless otherwise determined by the PLAN ADMINISTRATOR, all claims that have already been processed will not be reconsidered unless mandated by law.

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PLAN DESCRIPTION

Purpose

The Plan Document details the benefits, rights, and privileges of COVERED PERSONS (as later defined), in a fund established by The City of Franklin and referred to as the "Plan." The Plan is a self-funded group health plan and the administration is provided through a Third Party CLAIMS ADMINISTRATOR. The Plan Document explains the times when the Plan will pay or reimburse all or a portion of Covered Expenses.

Effective Date

The effective date of the Plan is January 1, 2002; restated: January 1, 2003 and January 1, 2011.

CLAIMS ADMINISTRATOR

The CLAIMS ADMINISTRATOR of the Plan is Auxiant.

Name of Plan

The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan

Name and Address of PLAN ADMINISTRATOR

The City of Franklin
C/O Director of Administration
9229 W. Loomis Road
Franklin, Wisconsin 53132
(414) 425-7500

Name and Address of CLAIMS ADMINISTRATOR

Auxiant
2450 Rimrock Road
Suite 301
Madison, Wisconsin 53713
(800) 279-6772

EMPLOYER I.D. Number

39-6005897

Plan Number

501

Type of Benefit Provided

Medical, PRESCRIPTION DRUG and Dental Expense Coverage

Agent for Legal Service

The City of Franklin

Funding of the Plan

The City of Franklin and EMPLOYEE Contributions

Medium for Providing Benefits

The benefits are administered in accordance with the Plan Document by the CLAIMS ADMINISTRATOR.

Fiscal Year of the Plan

Begins January 1st and ends December 31st

Named FIDUCIARY and PLAN ADMINISTRATOR

The Named FIDUCIARY is the City of Franklin. The PLAN ADMINISTRATOR is The City of Franklin, who will have the authority to control and manage the operation and administration of the Plan. The Common Council for the City of Franklin has delegated the responsibility, authority, and duties of the PLAN ADMINISTRATOR to the Director of Administration. The PLAN ADMINISTRATOR (or similar decision-making body) has the sole authority and discretion to: establish the terms of the Plan; determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, the terms and provisions of the Plan, and the meaning of any alleged vague or ambiguous term or provision; determine payment of benefits or claims under the Plan; and to decide any and all other matters arising under the Plan. The PLAN ADMINISTRATOR has the final and discretionary authority to determine the Usual & Customary Fee.

Contributions to the Plan

The amount of contributions to the Plan is to be made on the following basis:

Contributions to the Plan are made by the EMPLOYER, which include COVERED EMPLOYEE and/or RETIRED EMPLOYEE and dependent contributions. The EMPLOYER reserves the right to increase or decrease COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent contributions requirements from time to time. Notwithstanding any other provision of the Plan, the EMPLOYER'S obligation to pay claims under the terms of the Plan will be limited to its obligation to make contributions to the Plan. Payment of claims in accordance with these procedures will discharge completely the EMPLOYER'S obligation with respect to such payments. In the event that the EMPLOYER terminates the Plan, the EMPLOYER and COVERED EMPLOYEES and/or RETIRED EMPLOYEES will have no further obligation to make additional premium contributions to the Plan as of the effective date of termination of the Plan.

Plan Modification and AMENDMENTS

Subject to any negotiated agreements, and as otherwise allowed by statutory authority or not disallowed by statutory restrictions, the EMPLOYER may modify, amend, suspend, or discontinue the Plan without the consent of or notice to EMPLOYEES and/or RETIRED EMPLOYEES. Any changes made shall be binding on each COVERED EMPLOYEE and/or RETIRED EMPLOYEES and on any other COVERED PERSONS. Changes in the plan may occur in any or all parts of the plan including, but not limited to, benefit coverage, deductibles, maximum, copayments, exclusions, limitations, definitions, eligibility and the like. This right to make AMENDMENTS shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The EMPLOYER reserves the right at any time to terminate the Plan. The termination must be in writing. All previous contributions by the EMPLOYER may be used to pay benefits under the provisions of this Plan for claims arising before termination, or may be used to provide similar health benefits to COVERED EMPLOYEES and/or RETIRED EMPLOYEES, until all contributions are exhausted.

Plan is not a Contract

The Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment, to give any COVERED EMPLOYEE and/or RETIRED EMPLOYEE of the EMPLOYER the right to be retained in the service of the EMPLOYER, or to interfere with the right of the EMPLOYER to discharge or otherwise terminate the employment of any COVERED EMPLOYEE and/or RETIRED EMPLOYEE.

Claim Procedure

The EMPLOYER will provide adequate notice in writing to any COVERED EMPLOYEES and/or RETIRED EMPLOYEES whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the COVERED EMPLOYEE and/or RETIRED EMPLOYEE. Further, the EMPLOYER will afford a reasonable opportunity to any COVERED EMPLOYEE and/or RETIRED EMPLOYEE, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the EMPLOYER for that purpose.

Protection against Creditors

Benefit payments under this Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind. Any attempt to sell, transfer, garnish, or otherwise attach benefit payments under the plan in violation of this restriction will be void. If the EMPLOYER discovers an attempt has been made to attach, garnish, or otherwise improperly assign or sell a benefit payment in violation of this section that would be due to a current or former COVERED EMPLOYEE and/or RETIRED EMPLOYEE, the EMPLOYER reserves the right to terminate the interest of that individual in the payment, and instead apply that payment to or for the benefit of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE, dependents or spouse as the EMPLOYER may otherwise decide. The application of the benefit payment in this manner will completely discharge all liability for such benefit payment.

National Correct Coding Initiative

Where not otherwise specified, this Plan follows National Correct Coding Initiative (NCCI) for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The PLAN ADMINISTRATOR has full discretionary authority to select guidelines and/or vendors to assist in determinations.

Use of Pronouns in this Plan Document

Any references to "COVERED PERSON", "He", or "Himself" means the eligible COVERED EMPLOYEE, RETIRED EMPLOYEE, or covered dependent.

*Note: The following section is an overview of the Plan.
In event of a conflict, the Plan itself shall prevail.*

**BENEFIT OVERVIEW
FOR
The City of Franklin**

Eligibility Provisions

The COVERED EMPLOYEE and/or RETIRED EMPLOYEE should notify the EMPLOYER of eligibility changes (i.e., TOTAL DISABILITY, retirement, MEDICARE eligibility, change in dependent status –birth, marriage, divorce, etc.) as soon as possible.

EFFECTIVE DATE OF PLAN January 1, 2002; restated: January 1, 2003 and January 1, 2011

ELIGIBLE CLASS COVERED EMPLOYEE and/or RETIRED EMPLOYEE Classes as defined by the EMPLOYER (Please contact the EMPLOYER for an updated list of Eligible Classes).

EMPLOYEE EFFECTIVE DATE An individual will be eligible on the first day of the calendar month after the date of hire and when the COVERED EMPLOYEE and/or RETIRED EMPLOYEE satisfies all of the following:

- The Eligibility Requirement.
- The active EMPLOYEE Requirement.
- The Enrollment Requirements of the Plan.

Part-time EMPLOYEES and/or RETIRED EMPLOYEES of the EMPLOYER, who become full-time, REGULAR BASIS EMPLOYEES, are subject to the Waiting Period.

CONTRIBUTION The Plan may be evaluated from time to time to determine the amount of COVERED EMPLOYEE and/or RETIRED EMPLOYEE contribution (if any) required.

In the event the Federal or State law and/or administrative guidelines requiring these provisions is repealed, amended, clarified, or further defined, the affected provision will revert to the provision in the Plan that was in existence immediately prior to this change or will be amended to reflect any new required benefit level which may continue to exceed benefit levels prior to the adoption of Affordable Care Act.

Unless otherwise determined by the PLAN ADMINISTRATOR, all claims that have already been processed will not be reconsidered unless mandated by law.

** Please see the **Eligibility for Coverage** section for further details.*

**HOSPITAL PRE-ADMISSION CERTIFICATION
CONTINUED STAY REVIEW**

MANAGED CARE

The Plan requires that all non-emergency inpatient hospitalizations (Hospital, Skilled Nursing facility, Birthing center and other facilities) be pre-certified by the REVIEW ORGANIZATION at least 24 hours prior to the hospitalization; all emergency inpatient hospitalizations must be reported within 48 hours or by the end of the second business day after the admission. However, the attending PHYSICIAN does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. If an in-HOSPITAL stay is not pre-certified by the REVIEW ORGANIZATION, benefits related to the hospitalization will be reduced by \$500. (The penalty does not apply to the Annual DEDUCTIBLE or Out-of-Pocket Maximum.)

Please refer to the **Managed Care section for further details.*

PLAN LIMITATIONS AND MAXIMUMS OVERVIEW

NEGOTIATED FEE or
USUAL AND CUSTOMARY

All charges are subject to either the
NEGOTIATED FEE (if the Provider is a
Network Provider) or the USUAL AND
CUSTOMARY (U&C) fee for the area in
which the service or supply is received.

HOSPITAL ROOM AND BOARD Limitation

SEMI-PRIVATE rate

INTENSIVE CARE UNIT Limitation

ICU rate

SKILLED NURSING FACILITY ROOM
AND BOARD Limitation

SEMI-PRIVATE rate
90 days per CONFINEMENT

Maximum Benefit for All Medical
Expenses for 2011 (Includes all other
maximums).

\$1,000,000 per PLAN YEAR

Maximum Benefit for All Medical
Expenses for 2012 (Includes all other
maximums).

\$1,250,000 per PLAN YEAR

Maximum Benefit for All Medical
Expenses for 2013 (Includes all other
maximums).

\$2,000,000 per PLAN YEAR

Maximum Benefit for All Medical
Expenses for 2014 (Includes all other
maximums).

Unlimited

Maximum Benefit for TMJ
(Temporomandibular Joint Disorder)

\$1,250 per CALENDAR YEAR for
Non-surgical treatment only

Maximum Benefit for Home Health Care

40 visits per 12 months

**SCHEDULE OF MEDICAL BENEFITS
PPO NETWORK PLAN**

In the event the Federal or State law and/or administrative guidelines requiring these provisions is repealed, amended, clarified, or further defined, the affected provision will revert to the provision in the Plan that was in existence immediately prior to this change or will be amended to reflect any new required benefit level which may continue to exceed benefit levels prior to the adoption of Affordable Care Act.

Unless otherwise determined by the PLAN ADMINISTRATOR, all claims that have already been processed will not be reconsidered unless mandated by law.

The Plan utilizes a Preferred Provider Organization(s) (PPO) that, through negotiation, offers discounts for using the preferred providers for medical care. If the COVERED PERSON utilizes the PPO providers for eligible services, the COVERED PERSON will receive the Network benefit listed below. To obtain a list of the preferred providers, please reference the information provided on the ID card.

ALL services under the PPO Plan must be provided by participating providers to be covered at the Network benefit level. Services received elsewhere will be paid at the Non-Network level. If any of the following circumstances apply, however, benefits will be payable at the Network level:

- *Charges for pathologist, independent lab, emergency room PHYSICIANS, anesthesiologist, or radiologist when services are provided at a Network facility or referred by a Network provider, even when the provider is a Non-Network Provider.*

Plan F789-17 (formerly Plan G)

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2011 (Includes all other Maximums)	\$1,000,000	
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2012 (Includes all other Maximums)	\$1,250,000	
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2013 (Includes all other Maximums)	\$2,000,000	
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2014 (Includes all other Maximums)	Unlimited	
Note: The Network and Non-Network DEDUCTIBLE, Out-of-Pocket maximums and any other benefit maximums cross-satisfy one another.		

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
DEDUCTIBLE, PER CALENDAR YEAR		
Per COVERED PERSON*	None	\$200
Per FAMILY UNIT*	None	\$600
*Note: The Plan will credit \$50 towards a COVERED PERSON'S DEDUCTIBLE for inpatient HOSPITAL care or inpatient surgery once per person in a CALENDAR YEAR.		
The DEDUCTIBLE does not apply to: <ul style="list-style-type: none"> • Network PREVENTIVE CARE; • Routine vision exam; • Routine Immunizations (to age 6); and • Ambulance charges; and • Health Risk Assessment 		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Includes DEDUCTIBLE)		
The Out-of-Pocket is the amount paid by the COVERED PERSON in the CALENDAR YEAR. Charges noted below as not applying to the Out-of-Pocket do not calculate toward the Maximum Out-of-Pocket amount.		
Per COVERED PERSON	\$400	\$1,600
Per FAMILY UNIT	\$1,200	\$4,800
The Plan will pay the designated percentage of COVERED MEDICAL EXPENSES until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of COVERED MEDICAL EXPENSES for the rest of the CALENDAR YEAR unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: <ul style="list-style-type: none"> • Co-payments; • Cost containment penalties; and • Ineligible charges. 		
COVERED SERVICES		
Ambulance Service	90%	Paid at Network level
Ambulatory Surgery Center	90%	70% after DEDUCTIBLE
Autism Spectrum Disorders	90%	70% after DEDUCTIBLE
Chiropractic/SPINAL MANIPULATION	90%	70% after DEDUCTIBLE
Custom Molded Foot Orthotics	90%	70% after DEDUCTIBLE
Diabetic Supplies (see the PRESCRIPTION DRUG section for diabetic medications covered under the PRESCRIPTION DRUG Program)	90%	70% after DEDUCTIBLE
DURABLE MEDICAL EQUIPMENT	90%	70% after DEDUCTIBLE
Health Risk Assessment	100%, DEDUCTIBLE waived	
Home Health Care 40 visits per 12-months maximum	90%	70% after DEDUCTIBLE

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
HOSPICE Care	90%	70% after DEDUCTIBLE
HOSPITAL Billed Services		
Inpatient ROOM AND BOARD Limited to the SEMI-PRIVATE room rate	90%	70% after DEDUCTIBLE
INTENSIVE CARE UNIT Limited to the HOSPITAL'S ICU Charge	90%	70% after DEDUCTIBLE
Inpatient Miscellaneous Charges	90%	70% after DEDUCTIBLE
OUTPATIENT Emergency Room*	\$100 co-payment, then 90%	Paid at Network level
*Note: For a VALID MEDICAL EMERGENCY only. See definition of VALID MEDICAL EMERGENCY as defined in the Definition section. The co-payment will be waived if COVERED PERSON is admitted to the HOSPITAL directly from the Emergency Room.		
OUTPATIENT Diagnostic Services	90%	70% after DEDUCTIBLE
OUTPATIENT SURGERY Services	90%	70% after DEDUCTIBLE
OUTPATIENT Other Services	90%	70% after DEDUCTIBLE
Jaw Joint/TMJ (Surgical and non-surgical treatment) \$1,250 CALENDAR YEAR maximum for non-surgical treatment	90%	70% after DEDUCTIBLE
Occupational Therapy (OUTPATIENT)	90%	70% after DEDUCTIBLE
Organ Transplants	90%	70% after DEDUCTIBLE
Other Covered Services	90%	70% after DEDUCTIBLE
OUTPATIENT Private Duty Nursing	90%	70% after DEDUCTIBLE
PSYCHIATRIC CARE- MENTAL DISORDERS and SUBSTANCE ABUSE		
Inpatient and TRANSITIONAL TREATMENT	90%	70% after DEDUCTIBLE
OUTPATIENT	90%	70% after DEDUCTIBLE
PHYSICIAN Services		
Inpatient visits	90%	70% after DEDUCTIBLE
OUTPATIENT visits	90%	70% after DEDUCTIBLE
Emergency Room PHYSICIAN visit	90%	Paid at Network level
Office visits	90%	70% after DEDUCTIBLE
Surgery	90%	70% after DEDUCTIBLE
Allergy testing	90%	70% after DEDUCTIBLE
Allergy serum and injections	90%	70% after DEDUCTIBLE

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
PHYSICAL THERAPY (OUTPATIENT)	90%	70% after DEDUCTIBLE
PREGNANCY Includes one mental health screening during a pregnancy for pre-partum depression and one mental health screening six months after a live birth, stillbirth, or miscarriage for postpartum depression.	Paid as any other Service	Paid as any other Service
PREVENTIVE CARE		
Routine Well Adult Care (Age 2 and older). The following are considered routine: Includes: Prostate screening Gynecological exam Pap smear Routine mammogram (dependent on age and frequency – see below) Routine physical exam X-rays Lab blood tests Routine endoscopic surgery- (Colonoscopies) (Age 50+) Members age 50+ shall be Allowed one (1) colonoscopy every ten (10) years with at least 10 years between each surgery date. Immunizations (age 6 & Older) Well Child exam Tobacco Use counseling and intervention (office) fees including augmented pregnancy-tailored counseling Mental Health Screening – 1 per Calendar Year	100%	Not Covered
Routine Mammograms – age 40 + At age 40+ a woman can receive one (1) exam per CALENDAR YEAR	100%	70% after DEDUCTIBLE
Routine Vision Exam –To, but not through, Age 5	100%	100%, DEDUCTIBLE waived, \$25 per CALENDAR YEAR maximum
Routine Vision Exam – age 5 and up \$25 per CALENDAR YEAR maximum	100%	100%, DEDUCTIBLE waived

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
Routine Well NEWBORN Care for the following: Screening for hearing loss, Screening for phenylketonuria (PKU), and Screening for sickle cell disease	100%	70% after DEDUCTIBLE
Routine Well NEWBORN Care (inpatient nursery charges, circumcision and related PHYSICIAN fees)	90%	70% after DEDUCTIBLE
Routine Well Child Care – To, but not through, Age 2 Includes: Office visit Routine physical examination Lab blood tests X-rays	100%	70% after DEDUCTIBLE
Routine Immunizations – To, but not through, Age 6 Includes: Diphtheria Pertussis Tetanus Polio Measles Mumps Rubella Hemophilus Influenza B Hepatitis B Varicella	100%	100%, DEDUCTIBLE waived
Routine Child Blood Lead Tests –To, but not through, Age 6	90%	70% after DEDUCTIBLE
Prosthetics	90%	70% after DEDUCTIBLE
SKILLED NURSING FACILITY (SEMI-PRIVATE room rate) 90 days per CONFINEMENT maximum	90%	70% after DEDUCTIBLE
Speech Therapy (OUTPATIENT)	90%	70% after DEDUCTIBLE
URGENT CARE CLINIC* (Free-standing facility)	\$50 co-payment, then 90%	\$50 co-payment, then 70% after DEDUCTIBLE
URGENT CARE ROOM* (HOSPITAL billed)	\$50 co-payment, then 90%	\$50 co-payment, then 70% after DEDUCTIBLE
*Note: For a VALID MEDICAL EMERGENCY only. See definition of VALID MEDICAL EMERGENCY as defined in the Definition section. The co-payment will be waived if the COVERED PERSON is admitted to the HOSPITAL directly from the URGENT CARE ROOM or Clinic.		

SCHEDULE OF PHARMACY BENEFITS*

Plan F789-17 (formerly Plan G)

A prescription is required for medications listed below. Prescription drugs can move to different Tiers at any time.

Pharmacy Option

Limited to a 30-day supply

GENERIC DRUGS, also insulin and covered birth control medications

Co-payment..... \$10.00

FORMULARY BRAND NAME DRUGS

Co-payment..... \$25.00**

NON-FORMULARY BRAND NAME DRUGS

Co-payment..... \$40.00**

SPECIAL PRESCRIPTION PROVISIONS

Aspirin (Males age 45 to 79 and Females age 55 to 79),
 Folic acid (Females only),
 Iron supplements (children age 6 to 12 months),
 Oral fluoride pills (children 6 months to 5 years), and
 Erythromycin ophthalmic ointment (newborn 0 to 3 months)

Co-payment.....\$0

Mail Order PRESCRIPTION DRUG Option

Available for maintenance drugs. Maintenance drugs are those taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.
 Limited to a 90-day supply

GENERIC DRUGS, also insulin and covered birth control medications

Co-payment..... \$20.00

FORMULARY BRAND NAME DRUGS

Co-payment..... \$50.00**

NON-FORMULARY BRAND NAME DRUGS

Co-payment..... \$80.00**

SPECIAL PRESCRIPTION PROVISIONS

Aspirin (Males age 45 to 79 and Females age 55 to 79),
Folic acid (Females only),
Iron supplements (children age 6 to 12 months),
Oral fluoride pills (children 6 months to 5 years), and
Erythromycin ophthalmic ointment (newborn 0 to 3 months)

Co-payment.....\$0

* Exclusions and Limitations apply

** If the COVERED PERSON chooses to receive a BRAND NAME DRUG when a generic substitute is available, the COVERED PERSON will have to pay the difference between the costs of the generic substitute in addition to the brand name co-payment. However, if the COVERED PERSON'S qualified practitioner will not allow a generic substitute only the brand name co-payment will apply.

SCHEDULE OF DENTAL BENEFITS

PAYMENTS	
DEDUCTIBLE, per CALENDAR YEAR	
Per COVERED PERSON	\$25
Benefit Classes	
Class I (Diagnostic & Preventive Services)	100%, DEDUCTIBLE waived
Class II (Basic Restorative Services)	75% after DEDUCTIBLE
Class III (Major Restoration Services)	50% after DEDUCTIBLE
Maximum Benefits	
Maximum CALENDAR YEAR benefit per Person for Classes I, II and III combined	\$1,000

ELIGIBILITY

EMPLOYEE ELIGIBILITY: EMPLOYEES and/or RETIRED EMPLOYEES who belong to an **Eligible Class** of EMPLOYEES and/or RETIRED EMPLOYEES are eligible for coverage under this Plan following the waiting period.

ELIGIBLE CLASS:

- COVERED EMPLOYEE and/or RETIRED EMPLOYEE Classes as defined by the EMPLOYER. (Please contact the EMPLOYER for an updated list of Eligible Classes.)
- A person is eligible for EMPLOYEE COVERAGE the first day he or she:
 1. is a Full-Time, Active EMPLOYEE of the EMPLOYER. For the purposes of this plan, an EMPLOYEE is considered to be Full-Time if he or she normally works at least 20 hours per week, is on the regular payroll of the EMPLOYER for that work, and the position has not been designated “without benefits” by the Common Council.
 2. Elected Officials.
 3. is a RETIRED EMPLOYEE of the EMPLOYER.
 4. is in a class eligible for coverage.
 5. is under an individual employment agreement.
 6. a spouse of a retired Police who can remain on the Plan (if under 65 and EMPLOYEE/RETIRED EMPLOYEE is removed before turning 65).

Note: Part-Time, temporary, emergency, and seasonal EMPLOYEES are not eligible.

WAITING PERIOD: A COVERED EMPLOYEE and/or RETIRED EMPLOYEE is eligible the first day of the calendar month after the date of hire and when the COVERED EMPLOYEE and/or RETIRED EMPLOYEE satisfies all of the following:

- The Eligibility Requirement.
- The Active EMPLOYEE Requirement.
- The Enrollment Requirements of the Plan.

A “waiting period” is the time between the first day of employment in an eligible class and the first day of coverage under the plan.

Temporary, part-time, emergency, and seasonal EMPLOYEES and/or RETIRED EMPLOYEES who become full-time EMPLOYEES will NOT be given credit towards satisfaction of the waiting period while employed on a temporary or part-time basis.

EMPLOYEE EFFECTIVE DATE

COVERED EMPLOYEE and/or RETIRED EMPLOYEE COVERAGE for services under the Plan shall become effective on the date that the COVERED EMPLOYEE and/or RETIRED EMPLOYEE became

eligible for the Plan, as long as that individual has completed a written application for coverage. That application for coverage must be completed in writing within 31 days of becoming eligible for enrollment for coverage to be effective on the date of eligibility. Please see the Enrollment section for all requirements of Timely, Special and late enrollments.

ACTIVE EMPLOYEE REQUIREMENT

A COVERED EMPLOYEE and/or RETIRED EMPLOYEE must be an active COVERED EMPLOYEE and/or RETIRED EMPLOYEE (as defined by this Plan) for this coverage to take effect.

A group health plan may not base rules for eligibility for coverage upon an individual's being "ACTIVELY AT WORK" if a health factor is present. If an EMPLOYEE is absent from work due to a health factor, the individual is considered to be ACTIVELY AT WORK for purposes of Plan eligibility.

DEPENDENT ELIGIBILITY

The following persons are eligible for DEPENDENT COVERAGE under this plan:

1. **LAWFUL SPOUSE** – A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S lawful spouse in the state of residence, living in the same country, if not legally separated or divorced. The PLAN ADMINISTRATOR may require documentation proving a legal marital relationship.

Not considered eligible for spousal coverage:

- a) Common Law spouses; and
- b) Same sex marriages/domestic partnerships

2. **CHILDREN TO AGE 26 UNDER THE PATIENT PROTECTION AND CARE ACT** - A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S child up to age 26 is eligible for coverage through this plan regardless of marital status, employment status, or existence of other coverage. However, if the child has coverage through their own employer or through their own spouse, then this coverage will pay all benefits as secondary to that coverage as outlined in the Coordination of Benefits section in this plan document. When the child reaches limiting age, coverage will end on the child's birthday.
3. **DEPENDENT CHILDREN TO AGE 27 UNDER THE WISCONSIN STATE MANDATE** – A child of the participant, regardless of dependency status for State or Federal Tax purposes, is eligible for coverage through the end of the month he or she reaches age 27, provided the child is unmarried, and is not eligible for coverage offered by their employer or the cost of that coverage exceeds the cost of coverage through this plan (the child must provide proof of the cost of that other coverage upon application and at least annually or upon request.)

Military Service Extension: An enrolled dependent child who is under age 27, unmarried and a full-time student whose status as a full-time student is interrupted by a call to full-time active military service duty will have up to 12 months after completing active duty to apply for full-time student status at an institution of higher education and will be able to enter and remain on the Plan past age 27 so long as the only reason for interruption of full-time student status was the call to active duty.

- "Full-time student" means a person who physically attends classes at an accredited secondary school, college or university with a regular teaching staff, curriculum, and

student body, and either: (1) attends the school for the number of credits, hours, or courses required by the school to be considered a full-time students; or (2) attends two or more schools for credits toward a degree, which, when combined, equal full-time status at one of the schools.

- A person continues to be a full-time student during periods of vacation or between term periods established by the institution, unless the person does not continue as a full-time student immediately following the period of vacation or term break. A person ceases to be a full-time student at the end of the month during which the person graduates or otherwise ceases to be enrolled in attendance at the institution on a full-time basis.
- **Medical Leave of Absence (Wisconsin Michelle's Law):** If the student has to drop full-time student status due to an INJURY or SICKNESS, the dependent will be covered through the end of the semester/term, unless they request a medical leave of absence. If the student qualifies for a medical leave of absence, coverage will continue for up to one year for treatment of said INJURY or SICKNESS. The student or covered parent will be required to submit a written request for a medical leave of absence to the PLAN ADMINISTRATOR, along with certification from the treating physician explaining the need for the medical leave of absence and the estimated period of leave. The plan sponsor may request any medical record or documentation from the provider and/or dependent as proof of the need for leave, and may request updates at the start of each term or semester.
- A student may continue to be an eligible dependent for their final year as a full-time student, even though they do not meet the necessary full-time credit hours, if one of the following is true:
 - i. If they are enrolled in an internship with relation to their area of study.
 - ii. They will have accrued enough credit hours to graduate at the end of their final year without maintaining full-time status.

4. DEVELOPMENTALLY DISABLED OR PHYSICALLY HANDICAPPED CHILDREN – A covered dependent child who reaches the limiting age and is TOTALLY DISABLED, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the COVERED EMPLOYEE and/or RETIRED EMPLOYEE for support and maintenance and unmarried. The PLAN ADMINISTRATOR may require, at reasonable intervals during the two years after the dependent reaches the limiting age, subsequent proof of the child's TOTAL DISABILITY and dependency.

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

5. CHILDREN ENTITLED TO COVERAGE – as the result of one of the following:
- a) QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO);
 - b) A National Medical Support Order;
 - c) Divorce Decree; and
 - d) Court Order.

The term "child" or "children" as referenced in the above sections includes the following:

- a) A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S natural child;

- b) A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S adopted child (from the date of placement);
- c) A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S stepchild, who lives in the EMPLOYEE'S household and as long as the natural parent remains married to the EMPLOYEE;
- d) A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S FOSTER CHILD;
- e) A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S grandchild until the dependent child's parent is age 18;
- f) Any other child for whom the COVERED EMPLOYEE and/or RETIRED EMPLOYEE has LEGAL GUARDIANSHIP or for a child for whom the COVERED EMPLOYEE and/or RETIRED EMPLOYEE had noted LEGAL GUARDIANSHIP on the child's 18th birthday (proof is required).

An "adopted child (from the date of placement)" refers to a child whom the COVERED EMPLOYEE and/or RETIRED EMPLOYEE has adopted or intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen on the date of such placement for adoption. The term placement means the assumption and retention by such COVERED EMPLOYEE and/or RETIRED EMPLOYEE of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

If both the wife and husband/mother and father are EMPLOYEES and/or RETIRED EMPLOYEES, they can be covered under each other's Plans as well as their own and their children may be covered as dependents of both the mother and father.

If a person covered under this Plan changes status from COVERED EMPLOYEE and/or RETIRED EMPLOYEE to dependent or dependent to COVERED EMPLOYEE and/or RETIRED EMPLOYEE, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for DEDUCTIBLES and all amounts applied to maximums.

Excluded dependents include other individuals living in the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S home, but who are not eligible as defined, and the legally separated or divorced former spouse of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE.

A dependent will be considered eligible for coverage on the date the COVERED EMPLOYEE and/or RETIRED EMPLOYEE becomes eligible for DEPENDENT COVERAGE, subject to all limitations and requirements of this Plan.

DEPENDENT COVERAGE EFFECTIVE DATE

Each COVERED EMPLOYEE and/or RETIRED EMPLOYEE who makes a written request, on a form approved by the COMPANY, for DEPENDENT COVERAGE for an eligible DEPENDENT shall be authorized for DEPENDENT COVERAGE; however, the effective date for DEPENDENT COVERAGE shall be established as follows:

1. If the COVERED EMPLOYEE and/or RETIRED EMPLOYEE makes such written request on or before the date he or she becomes eligible for DEPENDENT COVERAGE or within the time frame listed in "EMPLOYEE Eligibility" to enroll, the effective date for DEPENDENT COVERAGE for those persons who are then the EMPLOYEE and/or RETIRED EMPLOYEE'S dependents shall be the same as the COVERED EMPLOYEE and/or RETIRED EMPLOYEE'S eligibility date for participant coverage.
2. A **NEWBORN** or **adopted** child of a COVERED EMPLOYEE and/or RETIRED EMPLOYEE is automatically enrolled in this Plan for 60 days. If the COVERED EMPLOYEE and/or

RETIRED EMPLOYEE does not have DEPENDENT COVERAGE, the COVERED EMPLOYEE and/or RETIRED EMPLOYEE must enroll the child in order for coverage under this Plan to continue after the 60-day period ends. Charges for covered nursery care will be applied toward the Plan of the NEWBORN child. If the NEWBORN child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs. DEPENDENT COVERAGE for the child may be reinstated retroactively to the date of birth or adoption. The Covered EMPLOYEE and/or RETIRED EMPLOYEE must apply for coverage within 12 months after the birth or adoption and pay back all contributions plus interest.

Charges for covered routine PHYSICIAN care will be applied toward the Plan of the NEWBORN child. If the NEWBORN child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan, and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

3. If a dependent is acquired other than at the time of his or her birth due to a court order, decree, or marriage, coverage for this new dependent will be effective on the date of such court order, decree, or marriage provided DEPENDENT COVERAGE is in effect under the Plan at that time and proper enrollment is completed within thirty-one (31) days of the event. If the COVERED EMPLOYEE and/or RETIRED EMPLOYEE does not have DEPENDENT COVERAGE in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new dependent within the thirty-one (31) day period immediately following the date of the court order, decree, or marriage, then DEPENDENT COVERAGE will be retroactive to the date of the court order, decree, or marriage.

TIMELY ENROLLMENT

The enrollment will be "timely" if the enrollment form is completed no later than 31-days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

LATE ENROLLMENT

Enrollment for coverage is required within thirty-one (31) days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S and/or dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a LATE ENROLLEE. Some late enrollments may be made under the following Special Enrollment provision; however, if the Special Enrollment provisions do not apply, a LATE ENROLLEE will only be eligible to enroll during the Open Enrollment period designated by the COMPANY (which typically takes place in December).

A Plan is permitted to treat LATE ENROLLEES differently from individuals who enroll when first eligible, except with regard to health factors. A Plan may not treat LATE ENROLLEES differently based on health factors.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a LATE ENROLLEE.

The time between the date a LATE ENROLLEE first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1st.

SPECIAL ENROLLMENT PERIODS

The ENROLLMENT DATE for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a SPECIAL ENROLLEE first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage (proof is required). A COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent was covered under a group health plan or had health insurance coverage or coverage through a state Medicaid or Children's Health Insurance Program (CHIP) program at the time coverage under this Plan was previously offered to the individual.
2. If required by the PLAN ADMINISTRATOR, the COVERED EMPLOYEE and/or RETIRED EMPLOYEE stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and:
 - a. the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or other cancellation by the Medicaid or CHIP program providing coverage); or
 - b. EMPLOYER contributions towards the coverage were terminated; or
 - c. the COVERED PERSON reached or exceeded the PLAN YEAR maximum benefit within the plan.
4. The COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent requests enrollment in this Plan no later than 31-days after the date of exhaustion of COBRA coverage or the termination of coverage or EMPLOYER contributions, described above. Coverage will be effective as of the date the other coverage ended.
5. If the loss of coverage was through a Medicaid or CHIP program, the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent requests enrollment in this Plan no later than 60-days after the date of exhaustion or cancellation by the Medicaid or CHIP program. Coverage will be effective as of the date the other coverage ended.

If the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Special Enrollment for dependent beneficiaries:

If the COVERED EMPLOYEE and/or RETIRED EMPLOYEE is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and either

1. A person becomes a dependent of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE through marriage, birth, adoption or placement for adoption, OR
2. The dependent was previously covered through a Medicaid or CHIP program and has lost eligibility for coverage through said program;

the dependent (and if not otherwise enrolled, the COVERED EMPLOYEE and/or RETIRED EMPLOYEE) may be enrolled under this Plan as a covered dependent of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE. In the case of the birth or adoption of a child, the spouse of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE may be enrolled as a dependent of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE if the spouse is otherwise eligible for coverage.

The dependent Special Enrollment Period is a period of 31-days and begins on the date of the marriage, birth, adoption or placement for adoption. If the reason for enrollment is loss of coverage through a Medicaid or CHIP program, the Special Enrollment Period is a period of 60-days and begins on the date of loss of coverage through that plan.

The coverage of the dependent enrolled in the Special Enrollment Period will be effective:

1. in the case of marriage, the date of the marriage;
2. in the case of a dependent's birth, the date of birth;
3. in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or
4. in the case of a loss of coverage through Medicaid or CHIP, the date of the loss of said coverage.

OPEN ENROLLMENT

During the annual open enrollment period, typically every December, EMPLOYEES and/or RETIRED EMPLOYEES and dependents who are LATE ENROLLEES will be able to enroll in the Plan.

Benefit choices for LATE ENROLLEES made during the Open Enrollment period will become effective January 1st.

COVERED PERSON(s) will receive detailed information regarding open enrollment from their EMPLOYER.

Rehiring a Terminated EMPLOYEE

A terminated COVERED EMPLOYEE and/or RETIRED EMPLOYEE who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the COVERED EMPLOYEE and/or RETIRED EMPLOYEE is returning to work directly from COBRA coverage, this COVERED EMPLOYEE and/or RETIRED EMPLOYEE does not have to satisfy the requirements.

Reinstatement of Retiree Coverage

Qualified Retirees of The City of Franklin, who have discontinued coverage due to employment through another EMPLOYER, are eligible to re-enroll in The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan Franklin, Wisconsin once they are no longer actively employed by another EMPLOYER. The Retiree must fill out all paperwork to re-enroll in the Plan within 31-days of the loss of other employment (If the Retiree enrolls after the 31-day period, the Retiree may still be able to re-enroll in the Plan under the Late Enrollment Provision).

Individuals Previously Denied Coverage Based on a Health Factor

Individuals who were previously denied coverage based on a health factor before HIPAA took effect for the Plan and have never been given subsequent opportunity to enroll must be given the chance to enroll. The individual has the option to begin coverage retroactively to the date the Plan became subject to HIPAA (renewal month beginning on or after 7/1/97) or prospectively from the date he or she requests enrollment in the Plan.

MANAGED CARE

Managed Care is services used by the Plan to help keep health costs down. They are a way to review and advise COVERED PERSONS on how best to use their Plan benefits.

Managed Care Services Phone Number

Please refer to the EMPLOYEE ID card for the Managed Care Services phone number (same as Pre-certification phone number).

The patient or family member must call this number to receive certification of certain Managed Care Services. This call must be made at least 24 hours in advance of services being rendered or within 48 hours or the second business day after an emergency.

Any reduced reimbursement due to failure to follow Managed Care procedures will not apply toward the DEDUCTIBLE or the maximum out-of-pocket payment.

Please remember that pre-certification approval does not verify eligibility for benefits nor guarantee benefit payments.

UTILIZATION REVIEW

As part of a program designed to keep down escalating costs, this Plan contains a Pre-certification program. The program requires that the COVERED PERSON follow certain steps before being admitted to the HOSPITAL for inpatient treatment or before any listed service below.

The program consists of:

1. Pre-certification of the MEDICAL NECESSITY for the following non-emergency services before Medical and/or Surgical services are provided:

hospitalizations (Hospital, Skilled Nursing facility, Birthing center and other facilities);
2. Retrospective review of the MEDICAL NECESSITY of the listed services provided on an emergency basis;
3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending PHYSICIAN; and
4. Certification of services and planning for discharge from a MEDICAL CARE FACILITY or cessation of medical treatment.

The purpose of the program is to determine if a proposed HOSPITAL stay is appropriate and if the treatment is appropriate for the indicated diagnosis. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending PHYSICIAN or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges and/or the Plan will not consider that course of treatment as appropriate for the

indicated diagnosis. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending PHYSICIAN does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification

Before a COVERED PERSON enters a MEDICAL CARE FACILITY on a non-emergency basis, the utilization review administrator will, in conjunction with the attending PHYSICIAN, certify the care as appropriate for the indicated diagnosis. A non-emergency stay in a MEDICAL CARE FACILITY is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the COVERED PERSON. Contact the utilization review administrator at the telephone number on the ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the COVERED EMPLOYEE and/or RETIRED EMPLOYEE
- The name, Identification number, and address of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE
- The name of the EMPLOYER
- The name and telephone number of the attending PHYSICIAN
- The name of the MEDICAL CARE FACILITY, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency** admission to the MEDICAL CARE FACILITY, the patient, patient's family member, MEDICAL CARE FACILITY or attending PHYSICIAN must contact the utilization review administrator **within 48 hours or by the end of the second business day** after the admission.

The utilization review administrator will determine the number of days of MEDICAL CARE FACILITY CONFINEMENT authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the COVERED PERSON does not receive authorization as explained in this section, the ALLOWABLE EXPENSES will be reduced by \$500. In addition, no benefits will be payable for any expenses that are not MEDICALLY NECESSARY (as determined by the Utilization Review Administrator or the CLAIMS ADMINISTRATOR), nor will those expenses apply to the DEDUCTIBLE or Out-of-Pocket limit of the Plan.

Concurrent review, discharge planning

Concurrent review of a course of treatment and discharge planning from a MEDICAL CARE FACILITY are parts of the utilization review program. The utilization review administrator will monitor the COVERED PERSON'S MEDICAL CARE FACILITY stay or use of other medical services. They will

also coordinate either, the scheduled release, an extension of the MEDICAL CARE FACILITY stay, or an extension or cessation of the use of other medical services with the attending PHYSICIAN, Medical Care Facilities and COVERED PERSON.

If the attending PHYSICIAN feels that it is MEDICALLY NECESSARY for a COVERED PERSON to receive additional services or to stay in the MEDICAL CARE FACILITY for a greater length of time than has been pre-certified, the attending PHYSICIAN must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain SURGICAL PROCEDURES are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's COVERED PERSONS and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the MEDICAL NECESSITY of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending PHYSICIAN and who is affiliated in the appropriate specialty.

PRE-ADMISSION TESTING SERVICE

The medical benefits percentage payable will be paid for diagnostic lab tests and x-ray exams when:

1. performed on an OUTPATIENT basis within seven (7) days before a HOSPITAL CONFINEMENT;
2. related to the condition which causes the CONFINEMENT; and
3. performed in place of tests while HOSPITAL confined.

Coverage applies, absent the existence of any applicable exclusions, even if tests show that the condition requires medical treatment before the HOSPITAL stay or that the HOSPITAL stay is not required.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses, and recommends coordinated and/or alternate types of appropriate MEDICALLY NECESSARY care. The case manager consults with the patient, the family and the attending PHYSICIAN in order to develop a plan of care for approval by the patient's attending PHYSICIAN and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring HOSPITAL or SKILLED NURSING FACILITY;

- determining alternative care options; and
- assistance obtaining any necessary equipment and services.

The intent of Case Management is that it occurs when the alternate care will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The PLAN ADMINISTRATOR, attending PHYSICIAN, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the PLAN ADMINISTRATOR will direct the Plan to reimburse for MEDICALLY NECESSARY expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

MEDICAL EXPENSE BENEFITS

THROUGHOUT THE PLAN WHERE REFERENCE IS MADE, DIRECTLY OR INDIRECTLY, TO THE PLAN PAYING BENEFIT PERCENTAGES LISTED IN THE SCHEDULE OF MEDICAL BENEFITS OR PAYING OTHER BENEFIT AMOUNTS PROVIDED FOR HEREIN, SUCH PAYMENT(S) SHALL FIRST CONSIDER, AND WILL BE EXCLUSIVE OF, DEDUCTIBLES, COINSURANCE, AND EXCLUDED AMOUNTS.

Upon receipt of a claim, the Plan will pay the BENEFIT PERCENTAGES listed in the Schedule of Medical Benefits for ELIGIBLE EXPENSES INCURRED in each BENEFIT PERIOD nor would it include DEDUCTIBLE/COINSURANCE paid by the COVERED PERSON. The amount to be paid, in no event, shall exceed the Maximum PLAN YEAR Benefit stated in the Schedule of Medical Benefits.

The DEDUCTIBLE

The DEDUCTIBLE is the amount of COVERED MEDICAL EXPENSES which must be paid by the COVERED PERSON before Medical Expense Benefits are payable. The amount of the DEDUCTIBLE is shown in the Schedule of Medical Benefits. Each family member is subject to the DEDUCTIBLE up to the family maximum as shown in the Schedule of Medical Benefits. Each family member is subject to the Single DEDUCTIBLE up to the family maximum as shown in the Schedule of Medical Benefits.

DEDUCTIBLE Three Month Carryover

COVERED MEDICAL EXPENSES INCURRED in and applied toward the DEDUCTIBLE in October, November and December will also be applied toward the DEDUCTIBLE in the next CALENDAR YEAR. (Note: The DEDUCTIBLE that is carried over does not apply to the Out-of-Pocket for the new CALENDAR YEAR.)

Family DEDUCTIBLE Feature

If the family DEDUCTIBLE limit, as shown in the Schedule of Medical Benefits, is incurred by covered family members during the CALENDAR YEAR, no further DEDUCTIBLES will be required on any members for the rest of the year.

Common Accident Provision

If two or more covered members of a family sustain bodily INJURIES in the same accident, only one applicable annual individual medical DEDUCTIBLE amount will be applied for all covered expenses due to that accident during that year.

Benefit Payment

Each CALENDAR YEAR, benefits will be paid for the COVERED MEDICAL EXPENSES of a COVERED PERSON that exceed the DEDUCTIBLE. Payment will be made at the rate shown under the reimbursement rate in the Schedule of Medical Benefits. Additionally, benefits will not exceed the Maximum Plan Year Benefit Amount or any listed limit of the Plan.

USUAL AND CUSTOMARY Charges

Subject to the PLAN ADMINISTRATOR'S exercise of discretion, the Plan shall pay no more than the USUAL AND CUSTOMARY charge for covered services and/or supplies, after a deduction of all

amounts payable by COINSURANCE or DEDUCTIBLES. All charges must be billed in accordance with generally accepted industry standards.

The USUAL AND CUSTOMARY Charge shall be the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the same market area during the preceding CALENDAR YEAR, adjusted by the national Consumer Price Index medical care rate of inflation. The PLAN ADMINISTRATOR, or his/her designee, shall determine the average plan payment made and applicable market area using reasonably available information.

The PLAN ADMINISTRATOR, or his/her designee, may increase or decrease the amount payable based upon discretionary consideration of factors including the nature and severity of the condition being treated, the quality of the goods and/or services provided, and competitive factors affecting the reasonable availability of alternative sources for the services and/or supplies in the relevant geographic market during the relevant time period. In making such determinations the PLAN ADMINISTRATOR, or his/her designee, may exercise discretion to the full extent permitted by law.

Out-of-Pocket Limit

COVERED MEDICAL EXPENSES are payable at the percentage shown each CALENDAR YEAR until the Maximum Out-of-Pocket Amount shown in the Schedule of Medical Benefits is reached. Then, COVERED MEDICAL EXPENSES INCURRED by a COVERED PERSON will be payable at 100% (except for the charges excluded) for the rest of the CALENDAR YEAR.

When a family reaches the family Out-of-Pocket limit, COVERED MEDICAL EXPENSES for that family will be payable at 100% (except for the charges excluded) for the rest of the CALENDAR YEAR.

Maximum PLAN YEAR Benefit Amount

The Maximum PLAN YEAR Benefit Amount is shown in the Schedule of Medical Benefits. It is the total amount of benefits that will be paid under The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan for all COVERED MEDICAL EXPENSES INCURRED by a COVERED PERSON in a PLAN YEAR. If the EMPLOYER offers more than one (1) EMPLOYEE Health Care Plan, a COVERED PERSON who has reached the PLAN YEAR maximum under one Plan will not be eligible for benefits under any other EMPLOYER Health Care Plan.

Allocation and Apportionment of Benefits

The COMPANY reserves the right to allocate the DEDUCTIBLE amount to any eligible charges and to apportion the benefits to the COVERED PERSON and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the COVERED PERSON and all assignees.

Alternative Care

In addition to the COVERED MEDICAL EXPENSES specified, the CLAIMS ADMINISTRATOR (who throughout this section is acting on behalf of, in conjunction with, and under the oversight of the PLAN ADMINISTRATOR) may determine and pre-authorize other services to be covered hereunder which normally are excluded services or have limited coverage under this Plan. The attending PHYSICIAN or Case Manager must submit to the CLAIMS ADMINISTRATOR an Alternative Care plan which indicates the diagnosis and MEDICAL NECESSITY of the proposed medical services to be provided to the COVERED PERSON.

Based on this information, the CLAIMS ADMINISTRATOR and/or its Medical Consultant(s) will determine and approve the extent to which and the period of time for which such medical service(s) will be covered under this Plan. Further, the CLAIMS ADMINISTRATOR will make such a determination based on each circumstance. Any such approval does not obligate this Plan to provide coverage for the same or similar services for other COVERED PERSONS, or for the COVERED PERSON that may have had it done once already, nor be construed as a waiver of its rights to administer this Plan in accordance with its established provisions.

Medical ELIGIBLE EXPENSES

Medical ELIGIBLE EXPENSES are the following expenses that are incurred while coverage is in force for the COVERED PERSON. If, however, any of the listed expenses are excluded from coverage because of a reason described in the General Limitations section, those expenses will not be considered Medical ELIGIBLE EXPENSES.

The Plan will make payment for Medical ELIGIBLE EXPENSES subject to plan requirements and limitations including the BENEFIT PERCENTAGE and maximum amounts shown in the Schedule of Medical Benefits.

HOSPITAL Expenses

HOSPITAL expenses are the charges made by a HOSPITAL on its own behalf. Such charges include the following:

1. SEMI-PRIVATE ROOM AND BOARD. If a facility has only private rooms, or if a private room is MEDICALLY NECESSARY due to the diagnosed condition, the private-room rate will be allowable.
2. Necessary HOSPITAL services other than ROOM AND BOARD as furnished by the HOSPITAL, including but not limited to, general nursing services.
3. Special care units, including burn care units, cardiac care units, delivery rooms, BIRTHING CENTERS, INTENSIVE CARE UNITS, isolation rooms, Rehabilitation facilities, AMBULATORY SURGICAL CENTERS, operating rooms and recovery rooms.
4. OUTPATIENT Emergency Medical Care.
5. OUTPATIENT (including Ambulatory Surgery) charges.
6. Charges for dental care when provided for a child under age five (5), a person with a chronic disability, or a person with a MEDICAL CONDITION that requires hospitalization or general anesthesia for such dental care.

Skilled Nursing/Extended Care Facility Expenses

Skilled Nursing/Extended Care Facility Expenses are payable up to the maximum in the Schedule of Medical Benefits. With respect to charges made by a SKILLED NURSING FACILITY for the following services and supplies furnished by the facility, only charges incurred in connection with convalescence from an INJURY or SICKNESS. The CONFINEMENT must start within 24 hours after a HOSPITAL or prior SKILLED NURSING FACILITY CONFINEMENT for the same condition. These expenses include the following:

1. ROOM AND BOARD (if private room accommodations are used, the daily ROOM AND BOARD charges allowed will not exceed the facility's average SEMI-PRIVATE charges);
2. General nursing services;

3. Medical services customarily provided by the Skilled Nursing/Extended Care Facility with the exception of private duty or special nursing services and PHYSICIAN'S fees; and
4. Drugs, biologicals, dressings, and casts furnished for use during the CONVALESCENT PERIOD, but no other supplies.

Home Health Care Expenses

Home Health Care is subject to the limits stated in the Schedule of Medical Benefits. A PHYSICIAN (either the person's primary care PHYSICIAN or the primary PHYSICIAN in the HOSPITAL) must order Home Health Care, which must be provided by a licensed HOME HEALTH CARE AGENCY. A PHYSICIAN must certify that:

1. The COVERED PERSON would have to be HOSPITALIZED or inpatient at a SKILLED NURSING FACILITY if Home Health Care Services were not available;
2. It would cause the person's immediate family (spouse, children, parents, grandparents, siblings and their spouses) undue hardship to provide the necessary care; and
3. A licensed MEDICARE-certified HOME HEALTH CARE AGENCY will provide or coordinate the services.

Services must be provided according to a written HOME HEALTH CARE PLAN. Covered HOME HEALTH CARE SERVICES AND SUPPLIES include the following:

1. Evaluation of the need for a HOME HEALTH CARE PLAN and development of the plan by an R.N. or medical SOCIAL WORKER;
2. Home care visits by a PHYSICIAN;
3. Part-time or intermittent home health aide services that are supervised by a REGISTERED NURSE or medical SOCIAL WORKER and are MEDICALLY NECESSARY for patient's care;
4. Part-time or intermittent nursing care by or under the supervision of a REGISTERED NURSE;
5. Physical, respiratory, inhalation, occupational and speech therapy;
6. Medical equipment, supplies and medications prescribed by a qualified practitioner;
7. Lab services by or on behalf of a HOSPITAL, as long as they would have been covered for an inpatient CONFINEMENT; and
8. Nutritional counseling from or supervised by a registered dietician.

The plan covers a set number of visits per person in a twelve (12) month period, as stated in the Schedule of Medical Benefits. A Home Health Care visit is any visit of up to four (4) hours by a Home Health Care provider.

The plan does not pay Home Health Care benefits for the following:

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 meals delivered to the home.
5. Transportation to and from the patient's home.

HOSPICE Expenses

HOSPICE care for a terminally ill person provided in the HOSPICE Unit, an OUTPATIENT facility or the patient's home. A PHYSICIAN must order the care and based upon a diagnosis that the patient has no more than six months to live. The plan may extend HOSPICE care benefits beyond six months if the

patient's PHYSICIAN certifies that the patient is still terminally ill. Covered HOSPICE Services and Supplies are:

1. ROOM AND BOARD.
2. Part-time nursing care provided or supervised by a REGISTERED NURSE.
3. Part-time services of a home health aide.
4. PHYSICAL THERAPY provided by a licensed therapist.
5. Medical supplies, drugs and medical appliances prescribed by a qualified provider.
6. PHYSICIAN'S services, including consultation and case management.
7. Dietary counseling.
8. Services of a licensed SOCIAL WORKER for counseling the patient.
9. Bereavement counseling for the patient's immediate family.
10. Respite care. (Limited to 18 occurrences during a six month period, without prior approval of the PLAN ADMINISTRATOR)

HOSPICE care benefits do not include the following:

1. Private or special duty nursing, except as part of a HOME HEALTH CARE PLAN.
2. CONFINEMENT not required to manage pain or other acute chronic symptoms.
3. Services of volunteers.
4. Services of a SOCIAL WORKER other than a licensed clinical SOCIAL WORKER.
5. Homemaker or caretaker services including sitter or companion, housecleaning or household maintenance.
6. Financial or legal counseling, including estate planning or drafting a will.
7. Services of a licensed pastoral counselor if the patient or family member belongs to his or her congregation.
8. Funeral arrangements.

Organ/Tissue Transplant Expenses

Benefits are available to a COVERED PERSON who is a recipient of MEDICALLY NECESSARY covered services relating to artery/vein, bone marrow, liver, heart, lung (single and double), combination heart/lung, pancreas, pancreas/kidney, kidney and cornea. Eligible services include, but are not limited to, testing to determine transplant feasibility and donor compatibility; charges related to the transplant itself, and follow-up care (including diagnostic x-ray and lab; procedures to determine rejection or success of transplant; PHYSICIAN, lab, x-ray or HOSPITAL charges; and anti-rejection drugs).

Organ transplant expenses are those charges for services and supplies in connection with non-EXPERIMENTAL transplant procedures, subject to the following criteria:

Prior to January 1, 2013

1. When both the donor and the recipient are covered by the Plan, each is entitled to benefits.
2. When only the recipient is covered by the Plan, both the donor and the recipient are entitled to benefits. The donor's benefits are limited to those that are not covered by any other source, including, but not limited to, insurance coverage and government programs. Benefits to the donor apply to the recipient's coverage.
3. When only the donor is covered by the Plan, the donor is entitled to benefits. The donor's benefits are limited to those that are not covered by any other source, including, but not limited to, insurance coverage and governmental programs. No benefits are paid to the non-covered recipient.
4. Except for transplant of a cornea, the transplant must be MEDICALLY NECESSARY in the

- event the organ transplant is not performed.
5. Pre-approval is required. The plan will always pay secondary to any other coverage.

Commencing January 1, 2013

1. The recipient of the organ transplant must be a COVERED PERSON under this Plan.
2. Except for transplant of a cornea, the transplant must be MEDICALLY NECESSARY in the event the organ transplant is not performed.
3. Charges incurred by the donor are only payable if the donor has no other coverage available, i.e. a group health plan, a government program, or a research program, etc.
4. Pre-approval is required. The plan will always pay secondary to any other coverage.

The following will not be eligible for coverage under this benefit:

1. Expenses associated with the purchase of any organ.
2. Charges in connection with mechanical organs or a transplant involving a mechanical organ.
3. Services or supplies furnished in connection with the transportation of a living donor.
4. Expenses associated with a non-human organ transplant.

PHYSICIAN Services

The professional services of a PHYSICIAN for surgical or medical services including home and office visits, inpatient and OUTPATIENT HOSPITAL care and visits, and inpatient consultations. The ELIGIBLE EXPENSES for covered surgical services will be the NEGOTIATED FEE or the USUAL AND CUSTOMARY charges, whichever is applicable.

Charges for **multiple SURGICAL PROCEDURES** will be a covered expense subject to the following provisions:

1. If more than one surgery is performed during an operative session, the covered expenses will be limited: The USUAL AND CUSTOMARY fee for the primary surgery procedure will be payable; 50% of the USUAL AND CUSTOMARY fee for the secondary procedure will be payable; and 25% of the USUAL AND CUSTOMARY fee for the third and following procedures will be payable; except when multiple unrelated SURGICAL PROCEDURES are performed by two or more surgeons on separate operative fields, benefits will be based on the NEGOTIATED FEE or the USUAL AND CUSTOMARY fee for each surgeon's primary procedure. (If two or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the NEGOTIATED FEE or the USUAL AND CUSTOMARY fee or percentage allowed for that procedure.)
2. The USUAL AND CUSTOMARY fee for an assistant surgeon or physician's assistant is based on the USUAL AND CUSTOMARY fee for primary surgeon as follows: 20% for an assistant surgeon; and 10% for a physician's assistant.
3. Benefits are not payable for incidental procedures done during a covered surgery (e.g., the removal of a healthy appendix during abdominal surgery). Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental procedures.

Additional Covered Medical Expenses
In Or Out of the HOSPITAL

1. Charges for **acupuncture** when used in place of anesthesia for a covered surgery or treatment.
2. Charges for **allergens, allergy testing and allergy injections.**
3. Charges for **MEDICALLY NECESSARY** local air or ground **ambulance** service to and from the nearest HOSPITAL or nursing facility where emergency care or treatment is rendered, or for services performed by a paramedic/EMT which eliminates the need for transfer to a HOSPITAL. This Plan will only cover ambulance transportation when: 1) no other method of transportation is appropriate; 2) the services necessary to treat the **SICKNESS** or **INJURY** are not available in the HOSPITAL or nursing facility where the **COVERED PERSON** is receiving inpatient services; and/or 3) the HOSPITAL or nursing facility where the ambulance takes the **COVERED PERSON** is the nearest with adequate facilities unless the **PLAN ADMINISTRATOR** finds a longer trip was **MEDICALLY NECESSARY**.
4. Charges made by an **AMBULATORY SURGICAL CENTER** or **Urgent Care Center** when treatment has been rendered to treat an **ILLNESS** or **INJURY**.
5. Charges for the cost and administration of **anesthetic** in conjunction with a covered surgical or medical procedure. Charges for the administration of anesthetics by a licensed Anesthesiologist or a Certified **REGISTERED NURSE Anesthetist (C.R.N.A.)** are also covered.
6. Treatment for **Autism Spectrum Disorders**; "Autism Spectrum Disorder" means any of the following: Autism disorder, Asperger's syndrome, Pervasive developmental disorder not otherwise specified.

"Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

"Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

Subject to the requirements of the Wisconsin Statutes, this Plan provides coverage for treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:

A licensed physician, psychiatrist, a person who practices psychology, a social worker who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of a provider listed herein or as defined in the Wisconsin Statutes related to this mandate, a professional working under the supervision of a certified outpatient mental health clinic, a speech-language pathologist, and an occupational therapist.

The coverage provides for the statutory minimum coverage level per individual per year for Intensive-level services with a minimum of 30 to 35 hours of care per week for a minimum

duration of 4 years, and the statutory minimum coverage level per insured per year for Nonintensive-level services as published by the Commissioner of Insurance annually in the Wisconsin Administrative Register.

Notwithstanding the previous provisions, the minimum coverage monetary amounts or duration required for treatment need not be met if it is determined by a supervising professional, in consultation with the participant's physician, that less treatment is medically appropriate.

The coverage required is subject to deductibles, coinsurance, and/or copayments that generally apply to other conditions covered under the policy or plan.

7. **Blood lead tests** for covered dependent children under age six (6). Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health and Social Services.
8. Charges for the processing and administration of **blood or blood components**, including charges for the processing and storage of autologous blood. Blood is not covered if donated for the COVERED PERSON.
9. **Breast reduction** as deemed **MEDICALLY NECESSARY** and upon prior approval.
10. **Cardiac rehabilitation** as deemed **MEDICALLY NECESSARY** provided services are rendered (a) under the supervision of a **PHYSICIAN**; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the **MEDICAL CONDITION** ends; and (d) in a **MEDICAL CARE FACILITY** as defined by this Plan. Limited to Phase I and II only.
11. Visits, treatment, maintenance and consultations performed in connection with **CHIROPRACTIC CARE** with **SPINAL MANIPULATION** in a **PHYSICIAN'S** office setting and provided by a licensed M.D., D.O. or D.C.
12. Charges for **cochlear implants** for children under age eighteen (18).
13. Injections of **contraceptive** medication (Depo-Provera), including charges for administering. Charges for office visits and laboratory work related to **contraceptives**.
14. **Cosmetic services** and supplies to repair a defect caused by an **ACCIDENTAL INJURY** or to repair a dependent child's congenital anomaly if **MEDICALLY NECESSARY**.
15. Charges for services and supplies in relation to **diabetes** self-management programs. Such services must be **MEDICALLY NECESSARY** and prescribed by a **PHYSICIAN**. Also, installation and use of an insulin infusion pump, glucose monitor, and other equipment or supplies (needles, syringes, lancets, clintest, glucose strips and chem. strips may be covered under the **PRESCRIPTION DRUG** Program) in the treatment of diabetes. Coverage for an insulin infusion pump is limited to the purchase of one (1) pump per **CALENDAR YEAR**, and the pump must be used for thirty (30) days before purchase.
16. Charges for **dialysis** as an inpatient or at a **MEDICARE**-approved **OUTPATIENT** dialysis center.
17. Charges for the rental, up to the purchase price, of a wheelchair, **HOSPITAL** bed, iron lung, or other **DURABLE MEDICAL EQUIPMENT** or surgical equipment required for **MEDICALLY**

NECESSARY temporary therapeutic use or the purchase of this equipment if economically justified, whichever is less. It is recommended that the COVERED PERSON obtain pre-approval of the purchase. The Plan does not cover expenses due to misuse, or charges for repair and maintenance for rental equipment, without evidence of MEDICAL NECESSITY and approval of the PLAN ADMINISTRATOR.

18. Charges for **electrocardiograms**, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by PHYSICIANS throughout the United States.
19. Charges for one (1) routine **eye exam** per CALENDAR YEAR, as stated in the Schedule of Medical Benefits. Includes refractions.
20. Charge for initial contact lenses or **eyeglasses** following cataract surgery.
21. Charges for **health risk assessments** will be covered as stated in the Schedule of Medical Benefits.
22. Charges for external **hearing aids** for children under age eighteen (18) are covered, to a maximum of one hearing aid per child, per ear every three (3) years.
23. Charges for **home infusion therapy**, including the administration of nutrients, antibiotics, and other drugs and fluids intravenously or through a feeding tube.
24. Charges for **HOSPITAL admission kits**.
25. **Injections** of medications in the doctor's office or in the patient's home.
26. Charges for routine **mammograms** shall be covered according to the guidelines as outlined in the Schedule of Medical Benefits.
27. Charges for a MEDICALLY NECESSARY **mammoplasty** following a MEDICALLY NECESSARY mastectomy. Services include reconstruction of the breast on which the mastectomy has been performed and reconstruction of the other breast to produce symmetrical appearance. Breast prostheses, surgical brassieres (two (2) per Calendar Year) and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan.
28. **Mechanical medical devices**. Devices such as pacemakers, artificial hips, and artificial larynxes that are placed in the body to aid the function of a body organ.
29. Charges for dressings, sutures, casts, splints, crutches, braces, custom molded foot orthotics or other necessary **medical supplies**, with the exception of dental braces, orthopedic shoes, arch supports, elastic stockings, trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription. Special supplies are also covered. These must be prescribed by a qualified practitioner and be necessary for continuing treatment of an INJURY or SICKNESS. The Plan covers catheters, colostomy bags, belts and rings, flotation pads, needles and syringes (other than for use with insulin), oxygen and other gases.
30. Charges for an annual **Mental Health screening** for a Covered Person to determine need for treatment. For females covered by the Plan, at least one (1) screening during a PREGNANCY for

pre-partum depression and one (1) screening within six (6) months after a live birth, stillbirth, or miscarriage for postpartum depression.

31. HOSPITAL and PHYSICIAN charges, including circumcision, in relation to the routine care of a **NEWBORN**. Routine NEWBORN care is covered under the baby's claim and not under the mother's claim.

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

32. Charges for restorative or rehabilitative **occupational therapy** by a licensed OCCUPATIONAL THERAPIST due to a SICKNESS or INJURY, other than a functional nervous disorder, or due to surgery performed because of a SICKNESS or INJURY. Therapy must be ordered by a PHYSICIAN. Covered expenses do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

33. Charges for the following **oral surgery/dental services** whether performed by a DENTIST or a medical doctor will be considered as eligible medical expenses:

- a. Surgery to correct accidental INJURIES of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
- b. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
- c. Incision of the accessory sinuses, mouth, salivary glands or ducts.
- d. Surgical extraction of impacted teeth.
- e. Excision of exostosis of the jaw and hard plate.
- f. Frenectomy.
- g. Gingivectomy and mucogingival osseous surgery.
- h. Alveolectomy, unless performed as preparation for dentures.
- i. Functional osteotomies.
- j. Extraction and initial replacement of natural teeth with said natural teeth.
- k. Apicoectomy and root canal therapy performed in conjunction with an apicoectomy.
- l. External incision and drainage of cellulitis.
- m. Charges for dental services under the Medical Plan provided by a DENTIST when **MEDICALLY NECESSARY** are limited to services provided for the repair of damage to the jaw or sound natural teeth as the direct result of an ACCIDENTAL INJURY. The treatment must begin within twelve (12) months after the INJURY. INJURY as a result of chewing or biting will not be considered an ACCIDENTAL INJURY. This will not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

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

34. The initial purchase, fitting and repair of **ORTHOTIC APPLIANCES** such as braces, splints or

other appliances which are required for support for an injured or deformed part of the body as a result of a disabled congenital condition or an INJURY or SICKNESS. Custom molded foot orthotics are covered.

35. Charges for **OUTPATIENT HOSPITAL services** including: services and supplies provided for the treatment of an INJURY or SICKNESS; regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, **PHYSICAL THERAPY** and radiation therapy) when ordered by the attending **PHYSICIAN**; and Emergency Room charges, but only if incurred due to an Emergency accident and treatment is provided within 48 hours of the accident, a surgical procedure, or treatment of a SICKNESS which is a medical emergency.
36. Charges for **oxygen** and other gases, and their administration.
37. Treatment or services rendered by a licensed Physical Therapist in a home setting or at a facility or institution which has the primary purpose of providing medical care for a SICKNESS or INJURY. Charges for restorative or rehabilitative **PHYSICAL THERAPY** due to a SICKNESS or INJURY, or due to surgery performed because of a SICKNESS or INJURY will be eligible. The therapy must be in accord with a **PHYSICIAN'S** exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy.
38. Charges for **Pre-admission testing**. Tests must be done within seven (7) days before an inpatient stay and be related to the condition for which the COVERED PERSON is HOSPITALIZED.
39. Eligible **PREGNANCY** related expenses for a COVERED EMPLOYEE and/or RETIRED EMPLOYEE or a dependent, including **MEDICALLY NECESSARY** amniocentesis tests, are considered the same as any other **MEDICAL CONDITION** under the Plan.

Group health plans generally may not under Federal law, restrict benefit 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).

(See also "Abortion" in "General Limitations")

40. Charges for **PRESCRIPTION DRUGS** (as defined), including new drugs that have reached Phase Three Clinical Investigational for treatment of HIV Infection. **PRESCRIPTION DRUGS** are covered under the **PRESCRIPTION DRUG** card program that is not administered by the **CLAIMS ADMINISTRATOR**. There are no benefits available for **PRESCRIPTION DRUGS** under this Plan other than through the **PRESCRIPTION DRUG** Expense Benefit unless stated otherwise. Please see the section titled "**PRESCRIPTION DRUG** Expense Benefit" or contact the Human Resources Department for further information.
41. Fees for **private-duty nursing** when such services are **MEDICALLY NECESSARY**, including when:

- a. provided by REGISTERED NURSES (R.N.'s), LICENSED PRACTICAL NURSES (L.P.N.'s) or Licensed Vocational Nurses (LVN's) in the COVERED PERSON'S home;
 - b. prescribed by a PHYSICIAN for the treatment of a SICKNESS or INJURY when the COVERED PERSON is homebound; and
 - c. not more costly than alternative services that would be effective for diagnosis or treatment of the COVERED PERSON'S condition (Outpatient private duty nursing care on a 24-hour-shift basis is not covered, except as may be pre-approved by the PLAN ADMINISTRATOR as meeting this condition "c".)
42. Charges for **prosthetic** appliances used to replace a missing natural body part, such as artificial limbs, eyes, or larynx, and charges for repairs of such an appliance. Replacement devices and repair costs are covered only when required due to a pathological change or normal use. The Plan does not cover replacement due to misuse or maintenance costs.
43. **PSYCHIATRIC CARE.** MEDICAL EXPENSES for care, supplies and treatment of MENTAL DISORDERS and SUBSTANCE ABUSE.

TRANSITIONAL TREATMENT is treatment that is provided in a less restrictive manner and setting than inpatient treatment, but more intensive than OUTPATIENT treatment. TRANSITIONAL TREATMENT includes services or programs approved by the Department of Health Services such as adult day care programs, child and adolescent day treatment programs, services for the chronically psychologically ill in a community support program, services for alcohol and drug dependence in a residential treatment program, and services for alcoholism and other chemical dependence in a day treatment program. It also includes services in intensive OUTPATIENT programs provided in accordance with Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders of the American Society of Addiction Medicine.

Charges for OUTPATIENT treatment include related expenses for diagnostic lab tests and psychological testing. PRESCRIPTION DRUGS are covered to the extent provided for the PRESCRIPTION DRUG benefit.

This benefit does not include treatment of nicotine habit or addiction; treatment of being overweight or obese; marriage counseling; or court ordered examinations or counseling.

Collateral therapy performed with the family and family therapy is a covered service.

44. Charges for **radiation therapy** or treatment and for chemotherapy. The materials and services of technicians are included.
45. **Routine PREVENTIVE CARE.** Charges for routine PREVENTIVE CARE as described in the Schedule of Medical Benefits. Covered expenses include related charges for routine x-ray and laboratory tests, routine mammograms, routine pap smears, well child care, and routine endoscopic surgeries (e.g. colonoscopies, etc.).

When a claim is submitted, the PHYSICIAN'S office must code the claim to indicate PREVENTIVE CARE or this Plan will consider the claim as treatment of SICKNESS or INJURY.

46. **Second surgical opinions.** The PHYSICIAN who gives the second (or third) opinion may not be in practice with the PHYSICIAN who gave the first opinion.

47. Charges for restorative or rehabilitative **speech therapy** by a licensed SPEECH THERAPIST. Therapy must be ordered by a PHYSICIAN and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an INJURY; or (iii) a SICKNESS that is other than a learning or mental disorder.
48. Charges in relation to **sterilization** for the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and covered spouse only. However, the reversal of sterilization is not covered.
49. Charges for surgical and non-surgical treatment of **TMJ (temporomandibular joint disorder)**, craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone to the skull; conditions of the facial muscles used in expression or mastication; and symptoms including headaches. Benefits subject to the limit stated in the Schedule of Medical Benefits. The Plan does not cover orthodontic services or treatment. Care and treatment shall include, but are not limited to crowns, inlays, Physical Therapy and any appliance that is attached to or rests on the teeth.
50. Charges made by an **URGENT CARE CLINIC**.
51. Charges for **x-rays, microscopic tests, and laboratory tests** along with the related radiology and pathology charges. A qualified practitioner must perform the tests. Tests covered under the inpatient HOSPITAL Billed Services are not covered under this benefit. Dental x-rays are not covered unless related to a covered INJURY or oral surgery.

GENERAL LIMITATIONS

In addition to exclusions identified as or created by conditions of or requirements for a COVERED MEDICAL EXPENSE. The following exclusions and limitations apply to EXPENSES INCURRED by all COVERED PERSONS:

1. **Abortion.** Charges for service, supplies, care or treatment in connection with an elective abortion. This Plan does cover treatment of complications that arise after an abortion.
2. **Administrative costs.** Charges for the completion of a claim form or report, preparing or providing an itemized bill, or providing medical records or information in order to process a claim.
3. **Alternative medical treatments.** Charges for acupuncture (except for anesthetic purposes), hypnotherapy, holistic medicine, massage therapy, Rolfing, religious therapy, health education, homeopathy, reiki, reflexology, vitamin therapy or any type of goal oriented or behavior modification therapy, myo-functional therapy, and programs intended to provide complete personal fulfillment or harmony.
4. **Appointments – Missing or Broken.** Charges for missed or broken appointments.
5. **Behavioral problems.** Services, supplies, care or treatment in connection with behavioral problems or other MEDICAL CONDITIONS that do not constitute a distinct medical diagnosis.
6. **Cardiac rehabilitation.** Services and charges for Phase III and Phase IV cardiac rehabilitation.
7. **CHELATION THERAPY.** Charges in relation to CHELATION THERAPY except in the treatment of heavy metal poisoning.
8. **CLOSE RELATIVE.** Charges for services rendered by a PHYSICIAN, nurse, or licensed therapist if such PHYSICIAN, nurse, or licensed therapist is a CLOSE RELATIVE of the COVERED PERSON, or resides in the same household of the COVERED PERSON, or is related to the COVERED PERSON as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
9. **Cochlear implants.** Anything not provided for in the Covered Medical Expenses section of this Plan Document.
10. **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
11. **Congenital disease.** Care, services, or treatment for a congenital disease or anomaly, except to correct a functional defect.
12. **Consultations.** Charges for telephone, email, or internet consultations.
13. **Contraceptive medications.** Including oral contraceptives, biologicals, implants and devices. The Plan does cover injectable contraceptives.
14. **Copy charges.** Charges for the photocopying of medical records.

15. **COSMETIC PROCEDURES.** Charges in connection with the care or treatment of, or surgery performed for, a COSMETIC PROCEDURE. In addition, complications from a non-covered COSMETIC PROCEDURE are not covered. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an ACCIDENTAL INJURY or disfiguring disease (does not include scarring due to acne or chicken pox), or when rendered to correct a congenital anomaly (i.e., a birth defect) of a COVERED PERSON. Pre-authorization is recommended.
16. **Court costs.** Charges for court costs, penalties, interest upon judgment, investigative expenses, administrative fees or legal expenses.
17. **Court ordered services.** Services and supplies related to court ordered treatment; also coverage for court ordered examinations to rule on voluntary or involuntary commitment or detention.
18. **CUSTODIAL CARE.** Services or supplies provided mainly as a rest cure, maintenance or CUSTODIAL CARE.
19. **Dental services.** Charges for dental services or supplies for care or treatment of the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth, not specifically included in the covered benefit section described in this Plan. Pre-authorization is recommended. This exclusion also applies to dental implantology, including related prosthetic devices.
20. **Developmental delays.** Services, supplies and procedures to treat developmental delays, including developmental testing. Also care for learning disorders, charges for remedial education, and charges for services (other than diagnostic) for mental retardation or for non-treatable mental deficiency. Charges for the cost of treatment for autism, Asperger's Syndrome, and pervasive developmental disorder are covered, as specified in Covered Medical Expenses, if the treatment is provided by a licensed physician, psychiatrist, psychologist, a social worker who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of any of those providers, or a professional working under the supervision of an outpatient mental health clinic, a speech-language pathologist, or an occupational therapist.
21. **DWI.** Charges for services received as a result of INJURY or SICKNESS caused by or contributed to by driving while intoxicated.
22. **Education and/or training.** Charges for services or supplies in connection with education or training except as specifically covered elsewhere in this Plan.
23. **Embryo.** Procedure, services, or supplies related to the treatment of an embryo, zygote or fetus before birth. This does not apply to services provided to the mother as part of the mother's prenatal care.
24. **Excess charges.** Charges incurred in connection with services and supplies which are not necessary for treatment of an INJURY or SICKNESS or are in excess of the NEGOTIATED FEE or the USUAL AND CUSTOMARY charges, whichever is applicable.
25. **Exercise programs.** Exercise programs or recreational therapy for treatment of any condition, except for PHYSICIAN-supervised cardiac rehabilitation Phase I and Phase II, occupational therapy, or PHYSICAL THERAPY covered by this Plan.

26. **EXPERIMENTAL and/or Investigational procedures.** Charges for EXPERIMENTAL and/or investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States or are not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration. EXPERIMENTAL and/or investigational services include:
- a. care, procedures, treatment protocol or technology that:
 - i. is not widely accepted as safe, effective, and appropriate for the INJURY or SICKNESS throughout the recognized medical profession and established medical societies in the United States; or
 - ii. is EXPERIMENTAL, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies.
 - b. drugs, tests, and technology that:
 - i. the FDA has not approved for general use;
 - ii. are considered EXPERIMENTAL;
 - iii. are for investigational use; or
 - iv. are approved for a specific MEDICAL CONDITION but are applied to another condition.

The PLAN ADMINISTRATOR must make an independent evaluation of the EXPERIMENTAL/non-EXPERIMENTAL standings of specific technologies but may elect to seek, accept, use, and relay upon supporting documentation and analysis provided by other parties. The PLAN ADMINISTRATOR shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the PLAN ADMINISTRATOR will be final and binding on the Plan.

The Plan will rely on the Data Project of the American Medical Association, the National Institutes of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and the Congressional Office of Technology Assessment in determining Investigational or EXPERIMENTAL services. The PLAN ADMINISTRATOR will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials; is the research, EXPERIMENTAL, study or Investigational arm of on-going phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

27. **Eye care.** Lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. (See also Radial Keratotomy)
28. **False statement.** The Plan relies on the completeness and truthfulness of the information required to be given. If a COVERED PERSON has made any false statement or misrepresentations, or has failed to disclose or conceal any material fact, the Plan will be entitled to not make benefit payments.
29. **Foot care.** Charges for routine foot care, such as treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment or removal of corns, calluses, or trimming of toenails; except the services necessary in the treatment of a metabolic or peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy.
30. **Foreign travel.** If a COVERED PERSON receives medical treatment outside of the United States or its territories, benefits shall be provided for those charges to the extent that the services rendered are included as covered expenses in the Plan, and provided the COVERED PERSON did not travel to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

Additionally, charges for such treatment may not exceed the limits specified herein as USUAL AND CUSTOMARY in the area of residence of the COVERED PERSON in the United States. Fees and charges exceeding USUAL AND CUSTOMARY shall be disallowed as ineligible charges. Charges equal to or less than USUAL AND CUSTOMARY shall be considered. In no event shall benefit payment exceed the actual amount charged.

31. **FDA.** Any drugs which are not approved for marketing by the United States Food and Drug Administration (FDA) by issuance of a New Drug Application or other form of formal approval. This does not include new drugs which have reached Phase 3 clinical testing for the treatment of HIV. Also, any medical procedures or drug that is approved for use, but is not used for the specific indication that led to its approval.
32. **Gender identification problems.** Charges related to counseling for persons suffering from gender identification problems or services or supplies related to the performance of gender

transformation procedures.

33. **Genetic testing.** Care, treatment, or supplies related to genetic testing or counseling, unless **MEDICALLY NECESSARY** to treat an **INJURY** or **SICKNESS** related to a high-risk **PREGNANCY**.
34. **Government.** Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
35. **Hair.** Charges for wigs and artificial hair pieces, and care and treatment of hair loss, hair transplants or any drugs that promise hair growth, whether or not prescribed by a **PHYSICIAN**.
36. **Hearing aids.** Charges in connection with hearing aids, or examinations for the prescription or fitting of hearing aids, unless covered elsewhere in the Plan.
37. **Hearing test.** Charges for routine hearing tests.
38. **Hearing therapy.** Charges for hearing therapy.
39. **Home birth.** Charges for childbirth at home.
40. **HOSPITAL EMPLOYEES.** Professional services billed by a **PHYSICIAN** or nurse who is an **EMPLOYEE** of a **HOSPITAL** or Skilled Nursing or Extended Care Facility and paid by the **HOSPITAL** or facility for the services.
41. **Hospitalization for convalescent or rest care.** Charges for hospitalization when such **CONFINEMENT** occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual **SICKNESS** or **INJURY**.
42. **Illegal act.** Charges for services, supplies, care or treatment received as a result of **INJURY** or **SICKNESS** caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the **INJURY** resulted from an act of domestic violence, except when committing domestic violence, or a medical (including both physical and mental health) condition.
43. **Illegal drugs or medications.** Services, supplies, care or treatment to a **COVERED PERSON** for **INJURY** or **SICKNESS** resulting from that **COVERED PERSON'S** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a **PHYSICIAN**. Expenses will be covered for Injured **COVERED PERSONS** other than the person using controlled substances.
44. **Implants.** Charges related to maxillary or mandibular implants.
45. **Impotence.** Care, treatment, services, supplies, or medications in connection with treatment for impotence or sexual dysfunction. This includes sexual counseling or therapy, implants, hormonal therapy and medications.
46. **Incarcerated.** Charges for services or supplies received while incarcerated in a penal institution or in legal custody.

47. **Infertility.** Diagnosis and treatment of infertility, including artificial insemination or in vitro fertilization and all other procedures meant to induce ovulation and/or promote spermatogenesis and/or achieve conception; and all related treatment of infertility. In addition, services, supplies and procedures in connection with the PREGNANCY of a surrogate mother, donor semen or egg, and sperm banking.
48. **Maintenance therapies.** Charges for maintenance therapies, unless specifically listed as covered elsewhere in this Plan.
49. **Marital counseling.** Charges for services or supplies for marital counseling or training services including related religious or sexual counseling or training services. However, collateral and family therapy are covered.
50. **MEDICARE.** In accordance with the Coordination of Benefits, health care services covered by MEDICARE, if a COVERED PERSON has or is eligible for MEDICARE, to the extent benefits are or would be available for MEDICARE, except for such health care services for which under the applicable Federal law the Plan is the primary payer and MEDICARE is the secondary payer.
51. **No charge.** Expenses for which a charge would not ordinarily be made in the absence of this coverage.
52. **No obligation to pay.** Charges for which the COVERED PERSON is not (in the absence of this coverage) legally obligated to pay.
53. **No scientific evidence.** Any medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect on health outcomes. Scientific evidence is only evidence that is obtained from well-designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting.
54. **Non-compliance.** EXPENSES INCURRED due to or as a consequence of non-compliance with any applicable State or Federal statute or regulation.
55. **Non-covered procedure.** Charges in relation to complications from a non-covered procedure. However, in accordance with "Abortion" above, complications from a non-covered abortion are covered.
56. **Non-emergency HOSPITAL admission.** Care and treatment billed by a HOSPITAL for a non-medical Emergency admission on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
57. **Non-human organ transplant.** Any non-human organ transplant or any artificial organ transplant.
58. **Non-prescription medications.** Non-prescription medicines, vitamins, nutrients, and nutritional supplements, even if prescribed or administered by a PHYSICIAN.
59. **Not MEDICALLY NECESSARY.** Care and treatment that is not MEDICALLY NECESSARY.

60. **Not recommended by a PHYSICIAN.** Charges for care, treatment, supplies or services that are not recommended and approved by a PHYSICIAN, or are not recognized by the American Medical Association as generally accepted and MEDICALLY NECESSARY for the diagnosis and/or treatment of an active SICKNESS or INJURY; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
61. **Not rendered by a PHYSICIAN.** PHYSICIAN'S fees for any treatment or service that is not in the physical presence of a PHYSICIAN.
62. **Not specified as covered.** Non-traditional medical services, treatment, and supplies which are not specified as covered under this Plan.
63. **Nursing services rendered by someone other than a REGISTERED NURSE.** Charges for professional nursing services if rendered by someone other than a REGISTERED NURSE (R.N.) or LICENSED PRACTICAL NURSE (L.P.N.), unless such care was vital as a safeguard of the COVERED PERSON'S life, and/or unless such care is specifically listed as a covered expense elsewhere in the Plan. In addition, the Plan will not cover certified REGISTERED NURSES in independent practice (other than an anesthetist). This exclusion does not apply to PRIVATE DUTY NURSES as addressed elsewhere in this Plan.
64. **Nutritional consultation.** Nutritional consultation or instruction, service, or supplies for educational, vocational, or training purposes, except as specifically included as a covered benefit.
65. **Obesity.** Care and treatment of obesity or MORBID OBESITY, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another SICKNESS. This exclusion includes surgery such as stomach stapling, gastric bubble, intestinal or stomach bypass, and suction lipectomy.
66. **Occupational.** Expenses for INJURIES or SICKNESSES arising out of, or in the course of, any occupation or employment for wage or profit, and for which the COVERED PERSON is entitled to benefits under any Workers' compensation or Occupational Disease Law, whether or not any coverage for such benefits is actually in force.
67. **Orthopedic shoes.** Charges for orthopedic shoes, arch supports, or any such similar device, or for the prescription or fitting thereof unless covered elsewhere in the plan.
68. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-PRESCRIPTION DRUGS and medicines (except as required by law), and first-aid supplies and non-HOSPITAL adjustable beds.
69. **Plan design exclusions.** Charges excluded by Plan design as mentioned in this document.
70. **PRIMARY PLAN.** Any charges that would have been paid by the COVERED PERSON'S PRIMARY PLAN had the COVERED PERSON complied with all of the pre-certification requirements of that plan.
71. **Private duty nursing.** Services of a PRIVATE DUTY NURSE while in a HOSPITAL or other MEDICAL CARE FACILITY.

72. **Radial keratotomy.** Charges in relation to radial keratotomy, Lazik, corneal modulation, refractive keratoplasty or any similar procedure.
73. **Radioactive contamination.** Charges incurred as a result of the hazardous properties of nuclear material, except as may result from a course of covered treatment prescribed by a PHYSICIAN.
74. **Records – medical records.** See “Administrative costs” and “Copy charges”.
75. **Recreational or educational therapy.** Charges for services or supplies for recreational or educational therapy or forms of non-medical self-help or self-cure, including any related diagnostic testing, training for active daily living skills; or health club memberships. Charges for PHYSICIAN-supervised Phase I and Phase II cardiac rehabilitation, occupational or PHYSICAL THERAPY are covered by the Plan (See also Additional Covered Medical Expenses” “Cardiac rehabilitation”).
76. **Routine medical examinations.** Charges incurred for routine medical examinations or care, routine health checkups, or immunizations, except as specifically shown as a covered expense elsewhere in the Plan.
77. **Self-inflicted INJURY.** Charges in relation to intentionally self-inflicted INJURY or self-induced SICKNESS, unless as the victim of domestic violence or another criminal act or of a MEDICAL CONDITION whether mental or physical.
78. **Services before or after coverage.** Charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.
79. **Sex change.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, and medical or psychiatric treatment.
80. **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, except as otherwise specified elsewhere in the plan.
81. **Splints or braces for non-medical purposes.** Charges for splints or braces for non-medical purposes (i.e., support worn primarily during participation in sports or similar physical activities).
82. **Stand-by surgical team.** Charges for a stand-by surgical team, unless they perform surgery.
83. **Surgical sterilization reversal.** Charges related to or in connection with the reversal of a sterilization procedure.
84. **Third Party examination.** Non-medical evaluations for employment, marriage license, judicial or administrative proceedings, school, travel, or purchase of insurance, etc.
85. **Travel expenses.** Charges for travel or accommodations, whether or not recommended by a PHYSICIAN, except for ambulance charges as defined as a covered expense.
86. **Vision therapy.** A charge for vision therapy.

87. **Vocational rehabilitation.** Charges for vocational rehabilitation and service for educational or vocational testing or training.

88. **War.** Charges as a result of active participation in war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country and charges due to a declared or undeclared act of war or any act of international armed conflict.

DENTAL EXPENSE BENEFITS

THROUGHOUT THE PLAN WHERE REFERENCE IS MADE, DIRECTLY OR INDIRECTLY, TO THE PLAN PAYING BENEFIT PERCENTAGES LISTED IN THE SCHEDULE OF DENTAL BENEFITS OR PAYING OTHER BENEFIT AMOUNTS PROVIDED FOR HEREIN, SUCH PAYMENT(S) SHALL FIRST CONSIDER, AND WILL BE EXCLUSIVE OF, DEDUCTIBLES, COINSURANCE, AND EXCLUDED AMOUNTS.

Subject to the General Limitations and Exclusions of this Plan, reasonable charges incurred for the following dental expenses will be covered in accordance with the percentage of coverage, DEDUCTIBLE amounts and maximums listed or shown in the Schedule of Dental Benefits.

If an individual is covered by both the Medical and Dental Plan of the COMPANY, Medical benefits will be paid prior to Dental and benefits will not be coordinated between the two Plans.

PREDETERMINATION of Benefits

Before starting a dental treatment for which the charge is expected to be \$300 or more, a PREDETERMINATION of benefits form should be submitted.

A regular dental claim form is used for the PREDETERMINATION of benefits. The COVERED EMPLOYEE and/or RETIRED EMPLOYEE fills out the EMPLOYEE section of the form and then gives the form to the DENTIST.

The DENTIST must itemize all recommended services and costs and attach all supporting x-rays to the form.

The DENTIST should send the form to the CLAIMS ADMINISTRATOR at this address:

Auxiant
2450 Rimrock Road
Suite 301
Madison, Wisconsin 53713
Phone (800) 279-6772

The CLAIMS ADMINISTRATOR will notify the DENTIST of the benefits payable under the Plan. The COVERED PERSON and the DENTIST can then decide on the course of treatment, knowing in advance how much the Plan will pay. A PREDETERMINATION is only valid for 180 days. If treatment begins more than 180 days after the date of PREDETERMINATION, the COVERED PERSON should submit another treatment plan. PREDETERMINATION is not a guarantee of payment. Payment of covered expenses is subject to all plan provisions. To be a covered expense the work must be done while coverage is in effect.

If a description of the procedures to be performed, x-rays and an estimate of the DENTIST's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level. For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

Alternative Care

In addition to the covered dental expenses specified, the CLAIMS ADMINISTRATOR (who throughout this section is acting on behalf of, in conjunction with, and under the oversight of the PLAN ADMINISTRATOR) may determine and pre-authorize other services to be covered hereunder which normally are excluded services or have limited coverage under this Plan. The attending DENTIST must submit an Alternative Care plan to the CLAIMS ADMINISTRATOR which indicates the diagnosis and necessity of the proposed dental services to be provided to the COVERED PERSON.

Based on this information, the CLAIMS ADMINISTRATOR and/or its consultant(s) will determine and approve the extent to which and the period of time for which such dental service(s) will be covered under this Plan. Further, the CLAIMS ADMINISTRATOR will make such a determination based on each circumstance. Any such approval does not obligate this Plan to provide coverage for the same or similar services for other COVERED PERSONS, or for the COVERED PERSON that may have had it done once already, nor be construed as a waiver of its rights to administer this Plan in accordance with its established provisions.

The DEDUCTIBLE

The DEDUCTIBLE is the amount of covered dental expenses which must be paid by the Covered Person before Dental Expense Benefits are payable. The amount of the DEDUCTIBLE is shown in the Schedule of Dental Benefits.

DEDUCTIBLE Three-Month Carryover

Covered dental EXPENSES INCURRED in and applied toward the DEDUCTIBLE in October, November and December will also be applied toward the DEDUCTIBLE in the next CALENDAR YEAR.

Dental ELIGIBLE EXPENSES

The term "Covered Dental Expenses" means the EXPENSES INCURRED by or on behalf of a COVERED PERSON for charges made by a DENTIST for the performance of a dental service provided for in the Dental Expense Benefits when the dental service is performed by or under the direction of a DENTIST, is essential for the necessary care of the teeth, and begins while the COVERED PERSON is covered for dental benefits. If the actual performance of a dental service begins on a date other than the date the service was recommended or determined to be necessary, the dental service will be considered to begin on the date the actual performance of the service begins. For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or

gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply furnished. Covered dental expenses do not include any expenses that are in excess of the USUAL AND CUSTOMARY amount.

CLASS I – Diagnostic & Preventive Services

The limits on Class I services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more often than the limits shown.

1. Oral examinations and routine cleaning (prophylaxis) of teeth, but not more than two (2) exams per CALENDAR YEAR. This includes scaling of teeth.
2. Fluoride applied to the teeth, but not more than twice per CALENDAR YEAR; limited to unmarried dependent children under age 19. A fluoride treatment applied during a routine cleaning comprises two (2) separate dental services.
3. Dental x-rays:
 - a. Full mouth or panoramic, but not more than once per 36-month period, unless required because of an INJURY;
 - b. Bitewing x-rays, limited to twice per CALENDAR YEAR.
4. Space maintainers. Fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.
5. Dental sealants will be covered for dependents up to age eighteen (18) (through age 17) on permanent molars.

CLASS II – Basic Restorative Services

1. Emergency oral exams and palliative treatment for pain.
2. Oral surgery; Extractions and other oral surgery including pre- and post-operative care.
3. Periodontics (gum treatments). Periodontal cleanings and exams and other related procedures to treat a disease of the supporting tissues of the teeth. The Plan does not cover periodontal splinting, unless as a result of an ACCIDENTAL INJURY.
4. Endodontics. Root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
5. Restorative fillings: Amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.
6. General anesthesia for oral or dental surgery; Must be administered by a DENTIST and MEDICALLY NECESSARY because of a MEDICAL CONDITION that presents a high risk to the patient.
7. Antibiotic drugs. Injections by the attending DENTIST.

8. Local anesthesia and analgesia.

CLASS III – Major Restorative Services

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations that exceeds the cost for amalgam, synthetic porcelain, or plastic materials will be covered only when the teeth must be restored with gold.
2. Installation of crowns. Benefits do not include porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns for dependent children under age twelve (12).
3. Inlays and onlays.
4. Gold foil fillings.
5. Maintenance of inlays, onlays, crowns, and gold foil fillings.

Note: Replacement of an inlay, onlay, or crown will only be covered if it was installed at least five (5) years prior to its replacement. This provision will be waived when replacement is due to an ACCIDENTAL INJURY that occurred while the COVERED PERSON was covered under this Plan. This provision will be waived when replacement is required due to the involvement of an additional tooth surface. Replacement of an appliance that can be made serviceable will not be covered.

6. Study models for major and Prosthodontic services.
7. Installing removable partial and complete dentures. Includes six (6) months' post-installation care.
8. Initial installation of removable or fixed bridgework to replace one or more natural teeth.
9. Repair of crowns, bridgework, and removable dentures. Not covered during the first six (6) months after initial installation.
10. Rebased or relining of removable dentures. Limited to once every three (3) years. Not covered during the first six (6) months after installation.
11. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. Replacing a bridge or denture is covered only if the existing appliance was installed at least five (5) years before its replacement and cannot be made serviceable. This limitation will be waived if:
 - a. Replacement is DENTALLY NECESSARY because of the placement of a new opposing full denture;
 - b. Replacement is DENTALLY NECESSARY because of the extraction of additional natural teeth that leaves the appliance unserviceable;
 - c. The bridge or denture is damaged beyond repair while in the oral cavity. The INJURY must occur while the person is covered by the Plan;

- d. The existing denture is temporary, placed while the COVERED PERSON was covered under the Plan, and is being replaced by a permanent appliance within twelve (12) months after being placed.

12. Implants will be covered up to the Usual and Customary charge of crowns and/or bridges.

General Limitations

In addition to exclusions identified as or created by conditions of or requirements for a covered dental expense, the following exclusions and limitations apply to EXPENSES INCURRED by all COVERED PERSONS:

1. **Administrative costs.** Administrative costs of completing claim forms or reports, preparing or providing an itemized bill, or for providing dental records or information in order to process a claim.
2. **Appearance of the teeth.** Charges for services or supplies which have the primary purpose of improving the appearance of the teeth, rather than restoring or improving dental form or function. Some examples include the following: laminate and veneers. (see also "cosmetic")
3. **Appliances.** Charges for services or supplies for appliances, including night guards for the treatment of gum and bone disease or to limit tooth grinding or jaw clenching.
4. **Appointments – Missing or Broken.** Charges for missed or broken appointments.
5. **CLOSE RELATIVE.** Charges for services rendered by a PHYSICIAN, nurse, or licensed therapist if such PHYSICIAN, nurse, or licensed therapist is a CLOSE RELATIVE of the COVERED PERSON, or resides in the same household of the COVERED PERSON, or is related to the COVERED PERSON as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
6. **Congenital deformities.** Charges for services or supplies to correct congenital deformities, such as a cleft palate.
7. **Consultations.** Charges for telephone, email, or internet consultations.
8. **Cosmetic.** COSMETIC DENTISTRY, including personalization or characterization of dentures and crown facings, abutments or pontics posterior to the second bicuspid; or labial veneer laminates.
9. **Crowns primarily for orthodontia.** Charges for services or supplies for crowns placed for the primary purpose of periodontal splinting, altering vertical dimension, or restoring the closing of the upper and lower teeth (occlusion), also charges for pre-formed stainless steel crowns.
10. **Excess.** Charges in excess of the USUAL AND CUSTOMARY charge for services or supplies. Also that portion of any fee that is in excess of the fee for the DENTALLY NECESSARY treatment. That portion of any fee that is in excess of the services needed to restore the tooth or dental arch to contour and function.
11. **Excluded under medical.** Services that are listed under the Medical Expense Benefits General

Limitations.

12. **Government program.** Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
13. **Illegal.** Any dental expenses due to commission or attempt to commit a civil or criminal battery or felony.
14. **Infection control procedures.** Charges for infection control procedures (sepsis control - rubber gloves, gowns, etc.) when billed separately from actual dental treatment.
15. **Medical services.** Services that, to any extent, are payable under any medical expense benefit of the Plan. This includes PRESCRIPTION DRUGS, HOSPITAL charges, and services of an anesthesiologist.
16. **No Endorsement.** Dental services that do not have uniform professional endorsement.
17. **No obligation to pay.** Charges for which the COVERED PERSON is not (in the absence of this coverage) legally obligated to pay.
18. **Non-Dental Provider.** Fees for treatment by other than a DENTIST. The following services when performed by a licensed dental hygienist, working under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards, will be covered: scaling or cleaning of teeth and topical application of fluoride.
89. **Not specified as covered.** Non-traditional dental services, treatment, and supplies which are not specified as covered under this Plan.
90. **Occupational.** Expenses for INJURIES or SICKNESSES arising out of, or in the course of, any occupation or employment for wage or profit, and for which the COVERED PERSON is entitled to benefits under any Workers' compensation or Occupational Disease Law, whether or not any coverage for such benefits is actually in force.
19. **Oral hygiene.** Charges for oral hygiene, dietary instruction, or plaque control programs.
20. **Orthodontia.** Orthodontic treatment and orthognathic surgery.
21. **Personalization.** Personalization of dentures.
22. **Precision attachments.** Precision or semi-precision attachments.
23. **Prosthodontics on non-permanent teeth.** Prosthodontic services performed on teeth that are not permanent.
24. **Repair of orthodontic appliances.** Charges for repair or replacement of any orthodontic appliance.
25. **Replacement.** Charges for the replacement of lost, missing, or stolen appliances or duplicate appliances.
26. **Services before or after coverage.** Charges incurred prior to the effective date of coverage under

the Plan or after coverage is terminated, unless Extension of Benefits applies.

27. **Splinting.** Crowns, fillings, or appliances that are used to connect (splint) teeth or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or cosmetic. The Plan does cover splints required as a result of an ACCIDENTAL INJURY. Periodontal splinting is not covered.
28. **Study models.** Study models for any services other than major and prosthodontic.
29. **Temporomandibular joint disorder (TMJ).** Surgical and non-surgical treatment of any jaw problem, including appliances and therapy. Jaw joint problems include temporomandibular joint disorder; craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and the skull; conditions of the facial muscles used in expression or mastication; and symptoms such as headaches.
30. **Termination.** Charges for services or supplies for any treatment plan when a COVERED PERSON receives the services or supplies after the date of termination of coverage under this Plan.
31. **War.** Charges as a result of active participation in war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country and charges due to a declared or undeclared act of war or any act of international armed conflict.

PRESCRIPTION DRUG EXPENSE BENEFIT

Note: The CLAIMS ADMINISTRATOR does not administer the PRESCRIPTION DRUG Expense Benefits. Please contact the Prescription Benefit Manager at the phone number listed on the EMPLOYEE'S ID card for a complete list of covered and excluded PRESCRIPTION DRUGS.

The Plan will pay the USUAL AND CUSTOMARY charge of PRESCRIPTION DRUGS, less the co-payment listed in the Schedule of Benefits that is payable by the COVERED PERSON for each prescription and each refill of a prescription. The prescription co-payment is not eligible for benefits under the Medical Expense Benefits portion of this Plan.

When using the ID card at a participating pharmacy, the COVERED PERSON pays only the COPAYMENT amount. If the prescription is bought without using the ID card, the COVERED PERSON must pay the full cost of the prescription and submit a claim for the benefit. If a drug is bought from a non-participating pharmacy, the amount payable in excess of the amounts shown in the Schedule of Prescription Drug Benefits will be the ingredient cost and dispensing fee.

Mandatory GENERIC DRUG Provision. If the COVERED PERSON chooses to receive a BRAND NAME DRUG when a generic substitute is available, the COVERED PERSON will have to pay the difference between the costs of the generic substitute in addition to the brand name co-payment. However, if the COVERED PERSON'S qualified practitioner will not allow a generic substitute only the brand name co-payment will apply.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc. Because of volume buying, the mail order pharmacy is able to offer COVERED PERSONS significant savings on their prescriptions. Any one mail order prescription is limited to a 90-day supply.

Covered PRESCRIPTION DRUGS

- All drugs prescribed by a PHYSICIAN that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- All compounded prescriptions containing at least one (1) prescription ingredient in a therapeutic quantity.
- Injectable forms of covered drugs.
- Oral contraceptives; emergency contraceptive kits; diaphragms and other intrauterine devices.
- Impotence medications.
- Skin-lightening and de-pigmenting products.
- Vitamin A derivatives for dermatological and cosmetic use.

- Diabetic products and supplies including needles and syringes.
- Immunosuppressive drugs for organ transplant patients.
- Pre-natal vitamins.
- Medications for treating AIDS.
- Multiple sclerosis medications
- Medications for foreign travel
- Migraine medications
- Influenza medication

Limits to this Benefit

This benefit applies only when a COVERED PERSON incurs a covered PRESCRIPTION DRUG charge. The covered drug charge for any one (1) prescription will be limited to:

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

Excluded:

Under this Plan, the following drugs are never considered a prescription/refill, regardless of use or diagnosis:

1. Any drug for which reimbursement is available under any other group program or government program.
2. Drugs dispensed from or by any HOSPITAL, Extended Care Facility, clinic, or other institution to an inpatient or OUTPATIENT; such drugs are covered by the medical portion of the Plan.
3. Drugs dispensed by other than a retail or mail order pharmacy.
4. Drugs that do not require a written prescription of a licensed PHYSICIAN (with the exception of insulin, the syringes or needles for its administration, and diabetic supplies).

The charge for more than a thirty (30) day supply shall not be covered by the Plan unless the prescription is listed as a maintenance drug and eligible to be dispensed in greater number (90-day supply) under the PRESCRIPTION DRUG Agreement.

Additional exclusions are as follows:

1. **Administration.** Any charge for the administration of a covered PRESCRIPTION DRUG.
2. **Allergy.** Allergy desensitization agents or allergy serum.
3. **Appetite suppressants.** A charge for appetite suppressants, anorexiant, or dietary supplements.
4. **Blood or Plasma.** Charges for blood or plasma related products.
5. **Contraceptives.** Charges for contraceptive implants or injections.
6. **Cosmetic.** Any charge for cosmetic medications such as anabolic steroids or medications for hair growth or removal, unless specifically stated as covered.
7. **Devices.** A charge for any devices or appliances (except for needles and syringes necessary for the administration of insulin and diabetic supplies). These include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar devices.
8. **Dispensed or consumed on premise.** Drugs dispensed or consumed while in a nursing home, HOSPITAL, etc.
9. **EXPERIMENTAL.** EXPERIMENTAL drugs and medicines, even though a charge is made to the COVERED PERSON.
10. **FDA.** Any drug not approved by the Food and Drug Administration.
11. **Fluoride preparations.** Charges for fluoride preparations.
12. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
13. **Growth hormones.** Charges for human growth hormones.
14. **Immunization.** Immunization agents or biological sera.
15. **Infertility drugs.** Charges for infertility drugs.
16. **Inpatient medication.** A drug or medicine that is to be taken by the COVERED PERSON, in whole or in part, while HOSPITAL confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
17. **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to investigational use only."
18. **Medical exclusion.** A charge excluded under the General Limitations of the Medical Expense Benefit.
19. **Needles and syringes.** Hypodermic syringes and/or needles except when dispensed for use with insulin.

20. **No charge.** A charge for PRESCRIPTION DRUGS which may be properly received without charge under local, State, or Federal programs.
21. **Non-legend drugs.** Charges for non-legend drugs or over-the-counter prescriptions.
22. **No prescription.** Charges for services, supplies, or medications that are not prescribed by a PHYSICIAN. This does not apply to injectable insulin.
23. **Outside the United States.** Charges for medications obtained outside the United States.
24. **Oxygen.** A charge for oxygen.
25. **Over-the-counter medications.** Any charges for over-the-counter medications (except insulin, needles and syringes for its administration, and diabetic supplies).
26. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the PHYSICIAN.
27. **Smoking cessation drugs.** Charges for prescription smoking cessation drugs, or medications such as nicotine gum or smoking deterrent patches for smoking cessation.
28. **Take-home drugs.** Any expenses for HOSPITAL take-home drugs.
29. **Vitamins.** Nutritional supplements; vitamins, except prenatal vitamins.

TERMINATION OF COVERAGE

EMPLOYEE Termination

COVERED EMPLOYEE and/or RETIRED EMPLOYEE COVERAGE will automatically terminate immediately upon the earliest of the following dates, except as provided for in any Extension of Benefits provision:

1. The end of the CALENDAR MONTH the EMPLOYEE terminates employment.
2. The end of the CALENDAR MONTH the COVERED EMPLOYEE and/or RETIRED EMPLOYEE ceases to be in a class of participants eligible for coverage, including, but not limited to, when the EMPLOYEE'S Eligible Class is eliminated.
3. The date ending the period for which the last contribution is made if the COVERED EMPLOYEE and/or RETIRED EMPLOYEE fails to make any required contributions when due.
4. The date the Plan is terminated; or with respect to any participant benefit of the Plan, the date of termination of such benefit.
5. The date of the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S death.
6. The end of the CALENDAR MONTH in which the EMPLOYEE retires, unless he or she is eligible for and elects retiree coverage.
7. The effective date of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE'S request for termination of coverage.
8. The date the COVERED EMPLOYEE and/or RETIRED EMPLOYEE knowingly misrepresents/falsifies information to the Plan.

(Note: Termination of coverage based upon "the date an Employee enters the full-time military service of any country" was established by action of the Common Council and is not provided as a negotiated benefit to any group. Any subsequent action of the Common Council on this matter will be incorporated herein as required.)

Dependent Termination

DEPENDENT COVERAGE will automatically terminate immediately upon the earliest of the following dates, except as provided for in any Extension of Benefits provision:

1. The end of the CALENDAR MONTH the dependent ceases to be an eligible dependent as defined in the Plan.
2. The date of termination of the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S coverage under the Plan, except in the event of the retirement of a Police Officer or Police Supervisory as may be provided for by a collective bargaining agreement or other city policy.
3. The date the COVERED EMPLOYEE and/or RETIRED EMPLOYEE ceases to be in a class of participants eligible for DEPENDENT COVERAGE.

4. The date for which the last contribution is made if the COVERED EMPLOYEE and/or RETIRED EMPLOYEE fails to make any required contributions when due.
5. The date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefit.
6. The date the dependent enters full-time military duty.
7. The date the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S death occurs, except in the event of a Police Employee's death in the line of duty where upon continued coverage occurs in accordance with the collective bargaining agreement or other city policy.
8. The date the COVERED EMPLOYEE and/or RETIRED EMPLOYEE requests termination of coverage to be effective for him or herself; and/or his or her dependents.

EXTENSION OF BENEFITS

Paid Time Off

If an EMPLOYEE is absent from work, but is being paid for sick, vacation, donated vacation, or paid time off pay, the EMPLOYEE will remain eligible for the plan as long as they continued to be paid at least for the number of hours required for plan eligibility.

Continuation during EMPLOYER-Certified Disability

A person who is TOTALLY DISABLED on the date his or her coverage under this Plan ends may remain eligible for benefits under this Plan for the condition that resulted in the disability. The coverage will continue at no cost to the individual until the earlier of twelve (12) months or the date the individual is no longer under the care of a PHYSICIAN, no longer is TOTALLY DISABLED, or reaches a maximum benefit stated in the Plan.

Lay Off/Leave of Absence/Long-term Disability

Where Employee, Retiree, or dependent coverage is to be extended, continued, or provided for within this Plan as a result of an adopted city policy, collective bargaining agreement, or individual employment agreement, the PLAN ADMINISTRATOR shall notify the CLAIMS ADMINISTRATOR, in writing, of such a continuation event. (For example the adopted policy for all employees provides that an employee on an approved leave of absence may continue their current coverage for up to six (6) months provided the employee pays the full premium.

If the EMPLOYEE has not returned to work by the end of the continuation period, coverage is terminated and COBRA is offered.

This provision does not run concurrently with the FAMILY AND MEDICAL LEAVE ACT (FMLA). A leave of absence may extend an additional six months after FMLA.

FAMILY AND MEDICAL LEAVE ACT Provision

Regardless of the established leave policies mentioned elsewhere in this document, this Plan shall at all times comply with the FAMILY AND MEDICAL LEAVE ACT of 1993 and Wisconsin Family and Medical Leave Act, as may be amended from time to time and as promulgated in regulations issued by the Department of Labor and State of Wisconsin.

During any leave taken under the FAMILY AND MEDICAL LEAVE ACT, the EMPLOYER will maintain coverage under this Plan on the same conditions as coverage would have been provided if the COVERED EMPLOYEE had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the COVERED EMPLOYEE and his or her covered dependents if the COVERED EMPLOYEE returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated except for such coverage or benefit changes that have been applied generally across the board. For example, Pre-Existing Condition limitations and other Waiting Periods will not be imposed unless they were in effect for the COVERED EMPLOYEE and/or his or her dependents when Plan coverage terminated.

EMPLOYEE eligibility requirements, the obligations of the EMPLOYER and COVERED EMPLOYEE concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A Participant with questions concerning any rights and/or obligations should contact the PLAN ADMINISTRATOR or his EMPLOYER.

The FMLA Act generally provides for 12 weeks of leave for personal ILLNESS or INJURY or that of a family member. However, there are special time restrictions for the family of military EMPLOYEES who were injured during active duty in the armed forces:

1. **Leave During Family Member's Active Duty** -- EMPLOYEES who have a spouse, parent, or child who is on or has been called to active duty in the Armed Forces may take up to 12 weeks of FMLA leave yearly when they experience a "qualifying exigency."
2. **Injured Service member Family Leave** -- EMPLOYEES who are the spouse, parent, child, or next of kin of a service member who incurred a serious INJURY or ILLNESS on active duty in the Armed Forces may take up to 26 weeks of leave to care for the injured service member in a 12-month period (in combination with regular FMLA leave).

Uniformed Services Employment and Reemployment Rights Act (USERRA)

EMPLOYEES on Military Leave

EMPLOYEES going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to EMPLOYEES and their dependents covered under the Plan before leaving for military service.

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

COBRA Extension of Benefits

Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain EMPLOYEES and/or RETIRED EMPLOYEES and their families covered under The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform COVERED

PERSON(s) and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The PLAN ADMINISTRATOR The City of Franklin, 9229 W. Loomis Road, Franklin, Wisconsin 53132, (Phone (414) 425-7500). COBRA continuation coverage for the Plan is administered by The City of Franklin, 9229 W. Loomis Road, Franklin, Wisconsin 53132, (Phone (414) 425-7500). Complete instructions on COBRA, as well as election forms and other information, will be provided by the PLAN ADMINISTRATOR to COVERED PERSON(s) who become Qualified Beneficiaries under COBRA.

COBRA Continuation Coverage In General COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain COVERED PERSON(s) and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active EMPLOYEES and/or RETIRED EMPLOYEES who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Qualified Beneficiary Defined In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a COVERED EMPLOYEE and/or RETIRED EMPLOYEE, the spouse of a COVERED EMPLOYEE and/or RETIRED EMPLOYEE, or a dependent child of a COVERED EMPLOYEE and/or RETIRED EMPLOYEE. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
2. Any child who is born to or placed for adoption with a COVERED EMPLOYEE and/or RETIRED EMPLOYEE during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "COVERED EMPLOYEE and/or RETIRED EMPLOYEE" includes not only common-law EMPLOYEES and/or RETIRED EMPLOYEES (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a COVERED EMPLOYEE and/or RETIRED EMPLOYEE is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a COVERED EMPLOYEE and/or RETIRED EMPLOYEE during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Events Explained A Qualifying Event is any of the following if the Plan provided that the COVERED PERSON would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a COVERED EMPLOYEE and/or RETIRED EMPLOYEE.
2. The termination (other than by reason of the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S gross misconduct), or reduction of hours, of a COVERED EMPLOYEE'S employment.
3. The divorce or legal separation of a COVERED EMPLOYEE and/or RETIRED EMPLOYEE from the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S spouse.
4. A COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S enrollment in any part of the Medicare program.
5. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the COVERED EMPLOYEE and/or RETIRED EMPLOYEE, or the covered spouse or a dependent child of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a COVERED EMPLOYEE and/or RETIRED EMPLOYEE, or the spouse, or a dependent child of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a COVERED EMPLOYEE does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and family members will be entitled to COBRA continuation coverage even if they failed to pay the COVERED EMPLOYEE and/or RETIRED EMPLOYEE portion of premiums for coverage under the Plan during the FMLA leave.

Procedure for obtaining COBRA continuation coverage The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Election of COBRA and Length of Election period The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a COVERED EMPLOYEE and/or RETIRED EMPLOYEE who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a Federal law called the Trade Act of 2002, and the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the PLAN ADMINISTRATOR for further information.

Notifying the PLAN ADMINISTRATOR of the occurrence of a Qualifying Event. The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the PLAN ADMINISTRATOR or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the PLAN ADMINISTRATOR) will notify the PLAN ADMINISTRATOR of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or
4. enrollment of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the PLAN ADMINISTRATOR or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the PLAN ADMINISTRATOR or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Human Resource Department
The City of Franklin
9229 W. Loomis Road
Franklin, Wisconsin 53132

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage;
- the **name and address of the employee** covered under the plan;
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**; and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, such as in order to qualify for a disability extension.

Once the PLAN ADMINISTRATOR or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. COVERED EMPLOYEES and/or RETIRED EMPLOYEES may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost (if, under your plan, the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later [e.g., at the end of the month]). If the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or their spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Waiver of a Qualified Beneficiary's election rights before end of period If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the PLAN ADMINISTRATOR or its designee, as applicable.

Termination of a Qualified Beneficiary's COBRA continuation coverage. During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any COVERED EMPLOYEE and/or RETIRED EMPLOYEE.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary, whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension, is no longer disabled, whichever is earlier; or
 - b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, such as for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Maximum coverage periods for COBRA continuation coverage. The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the COVERED EMPLOYEE and/or RETIRED EMPLOYEE ends on the later of:
 - a. 36 months after the date the COVERED EMPLOYEE and/or RETIRED EMPLOYEE becomes enrolled in the Medicare program; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S termination of employment or reduction of hours of employment.
3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a COVERED EMPLOYEE and/or RETIRED EMPLOYEE during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Circumstances when the maximum coverage period may be expanded. If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The PLAN ADMINISTRATOR must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator.

Disability extension. A disability extension will be granted if an individual (whether or not the COVERED EMPLOYEE) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a COVERED EMPLOYEE'S employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the PLAN ADMINISTRATOR with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator.

Payment for COBRA continuation coverage. For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Payment for COBRA continuation coverage in monthly installments. Payment for COBRA continuation coverage is made in month installments. The Plan is also permitted to allow for payment at other intervals.

“Timely Payment” for COBRA continuation coverage. Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, COVERED EMPLOYEES and/or RETIRED EMPLOYEES or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the EMPLOYER and the entity that provides Plan benefits on the EMPLOYER'S behalf, the EMPLOYER is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage if one is offered by employer. If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Questions.

If a Covered Person has questions about COBRA continuation coverage, they should contact the COBRA Administrator or may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the PLAN ADMINISTRATOR informed of address changes.

In order to protect a Covered Person's family's rights, a Covered Person should keep the PLAN ADMINISTRATOR informed of any changes in the addresses of family members. The Covered Person should also keep a copy, for their records, of any notices they send to the PLAN ADMINISTRATOR.

COORDINATION OF BENEFITS

The Coordination of Benefits provision sets out rules for the order of payment of COVERED EXPENSES, including Medical, Dental, Vision, Prescription, or other coverage available under this plan, when two or more plans – including Medicare – are paying and prevents the payment of benefits that exceed expenses. It applies when the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or any eligible dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan or plans will not exceed 100% of ALLOWABLE EXPENSES. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

All benefits contained in the Plan are subject to this provision.

Definitions

The term "other plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, prescription drugs, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for COVERED PERSONS in a group whether on an insured or uninsured basis, including but not limited to:
 - a. HOSPITAL indemnity benefits.
 - b. HOSPITAL reimbursement-type plans which permit the COVERED PERSON to elect indemnity at the time of claims.
2. HOSPITAL or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. HOSPITAL or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (H.M.O.).
5. Any coverage for students which is sponsored by or provided through a school or other educational institution.
6. Any coverage under a governmental program (including Medicare) and any coverage required or provided by any statute/law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
7. Group automobile insurance.
8. Individual automobile insurance coverage on an automobile leased or owned by the COMPANY.
9. Individual automobile insurance coverage based upon the principles of "No-Fault" and/or

Personal INJURY Protection coverage.

10. Medical payment coverage under any group or individual automobile policy.
11. Federal government plans or programs. This includes Medicare.
12. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and to that portion that does not.

The term "ALLOWABLE EXPENSES" means any necessary item of expense, the charge for which is reasonable, regular, and customary, 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, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

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

The term "CLAIM DETERMINATION PERIOD" means a CALENDAR YEAR or that portion of a CALENDAR YEAR during which the COVERED PERSON for whom claim is made has been covered under this Plan.

Coordination Procedures

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all Other Plans will not exceed the total of ALLOWABLE EXPENSES INCURRED during any CLAIM DETERMINATION PERIOD with respect to a COVERED PERSON eligible for:

1. Benefits either as an insured person or participant or as a dependent under any other plan which has no provision similar in effect to this provision, or
2. Dependent benefits under this Plan for a COVERED PERSON who is also eligible for benefits:
 - a. As an insured person or participant under any other plan, or
 - b. As a dependent covered under another group plan.
 - c. If the dependent is a step child of the EMPLOYEE and/or RETIRED EMPLOYEE who is covered under the plan of the natural parent.
3. COVERED EMPLOYEE and/or RETIRED EMPLOYEE benefits under this Plan for a

COVERED EMPLOYEE and/or RETIRED EMPLOYEE who is also eligible for benefits as an insured person or participant under any other plan and has been covered continuously for a longer period of time under such other plan.

Order of Benefit Determination

Each plan makes its claim payment according to where it falls in this order, if MEDICARE is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans.
2. This Plan shall be "secondary" in coverage to any no fault automobile insurance policy, regardless of any election made to the contrary by a COVERED PERSON. Any available no-fault insurance shall be the "primary" coverage for any health care bills incurred as a result of any auto accident.
3. The plan which covers the claimant as a COVERED EMPLOYEE and/or RETIRED EMPLOYEE or named insured pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the claimant as a dependent.
4. If the claimant is a dependent child and not a step child as mentioned below, the plan of the parent or LEGAL GUARDIAN whose birthday occurs first in the CALENDAR YEAR shall pay first. If both parents and/or LEGAL GUARDIANS have the same birthday, the benefits of the benefit plan which has covered the dependent for the longer time are determined before those of the benefit plan which covers the other parent or LEGAL GUARDIAN. However, if the dependent child's parents or LEGAL GUARDIANS are divorced, then:
 - a. The plan of the parent or LEGAL GUARDIAN with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility; in which case, that parent's plan would pay first.
 - b. If the claimant is a step child of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE, then the plan of the natural parent will pay as primary, and plan of the step parent will pay as secondary.
 - c. The plan of the parent or LEGAL GUARDIAN without custody pays third.
 - d. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - e. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in

coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

5. The other plan covering the claimant as an active COVERED EMPLOYEE or a dependent of an active COVERED EMPLOYEE shall be primary.
6. The benefits of a plan which covers the claimant as a COVERED EMPLOYEE who is neither laid off nor retired, are determined before those of a plan which covers that person as a laid off or RETIRED EMPLOYEE. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
7. If a dependent, as defined by the Plan, has other coverage for which said individual is not listed as a "dependent", then the other coverage shall be primary and this coverage will be secondary.
8. If the order set out above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will pay first.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the COMPANY will have the right, exercisable alone and in its sole discretion, to pay to any insurance COMPANY or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the COMPANY will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan, rather than the amount payable in the absence of this provision.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the COMPANY may, without the consent of or notice to any person, release to or obtain from any insurance COMPANY or other organization or person any information, with respect to any person, which the COMPANY deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the COMPANY such information as may be necessary to implement this provision.

Effect of MEDICARE

It is the intent of the Plan to adhere to the laws of DEFRA, TEFRA, and COBRA as currently constituted and as amended from time to time and to the extent they apply to governmental organizations and plans. Any COVERED EMPLOYEE and/or RETIRED EMPLOYEE or dependent eligible for MEDICARE should contact the CLAIMS ADMINISTRATOR for current rulings.

If any COVERED PERSON eligible for MEDICARE fails to enroll therefore, benefits will be paid by the Plan as though the person had enrolled.

SUBROGATION, REIMBURSEMENT, AND/OR THIRD PARTY RESPONSIBILITY

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an INJURY, SICKNESS, disease or disability is caused in whole or in part by, or results from the acts or omissions of COVERED PERSON(s), Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "COVERED PERSON(s)") or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").
2. COVERED PERSON(s), his or her attorney, and/or LEGAL GUARDIAN of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the COVERED PERSON(s) agrees the Plan shall have an equitable lien on any funds received by the COVERED PERSON(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The COVERED PERSON(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a COVERED PERSON(s) settles, recovers, or is reimbursed by any Coverage, the COVERED PERSON(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the COVERED PERSON(s). If the COVERED PERSON(s) fails to reimburse the Plan out of any judgment or settlement received, the COVERED PERSON(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the COVERED PERSON(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the COVERED PERSON(s) is entitled, regardless of how classified or characterized.
2. If a COVERED PERSON(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any COVERED PERSON(s) may have against any Coverage and/or party causing the SICKNESS or INJURY to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may in its own name or in the name of the COVERED PERSON(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the COVERED PERSON(s) fails to file a claim or pursue damages against:

- a. the responsible party, its insurer, or any other source on behalf of that party;
- b. any first party insurance through medical payment coverage, personal INJURY protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. any policy of insurance from any insurance COMPANY or guarantor of a third party;
- d. worker's compensation or other liability insurance COMPANY; or,
- e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the COVERED PERSON(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the COVERED PERSON(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The COVERED PERSON(s) assigns sufficient rights as necessary to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the COVERED PERSON(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the COVERED PERSON(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the COVERED PERSON(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the COVERED PERSON(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable SICKNESS, INJURY, disease or disability.

D. Excess Insurance

If at the time of INJURY, SICKNESS, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law

or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- a. the responsible party, its insurer, or any other source on behalf of that party;
- b. any first party insurance through medical payment coverage, personal INJURY protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. any policy of insurance from any insurance COMPANY or guarantor of a third party;
- d. worker's compensation or other liability insurance COMPANY or
- e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

E. Separation of Funds

Benefits paid by the Plan, funds recovered by the COVERED PERSON(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the COVERED PERSON(s), such that the death of the COVERED PERSON(s), or filing of bankruptcy by the COVERED PERSON(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. Wrongful Death

In the event that the COVERED PERSON(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the COVERED PERSON(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. to provide the Plan with pertinent information regarding the SICKNESS, disease, disability, or INJURY, including accident reports, settlement information and any other requested additional information;
 - c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the COVERED PERSON(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said INJURY or condition, out of any proceeds, judgment or settlement received, the COVERED PERSON(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the COVERED PERSON(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the COVERED PERSON(s)' cooperation or adherence to these terms.

H. Offset

Failure by the COVERED PERSON(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the COVERED PERSON(s) may be withheld until the COVERED PERSON(s) satisfies his or her obligation.

I. Minor Status

1. In the event the COVERED PERSON(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

The PLAN ADMINISTRATOR retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. Additionally, note that the provision of this Plan that stipulates that the PLAN ADMINISTRATOR may amend the Plan at any time without notice applies to this provision as well.

K. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

DEFINITIONS

ACCIDENTAL INJURY

A condition which is the result of bodily INJURY caused by an external force and happening by chance or without intention or design, or a condition caused as the result of an incident which results in unexpected consequences.

ACTIVELY AT WORK

An EMPLOYEE is considered ACTIVELY AT WORK when they are on the regular payroll of the EMPLOYER and have begun to perform the duties of his or her job with the EMPLOYER on a full-time basis.

ALLOWABLE EXPENSES

Any USUAL AND CUSTOMARY expense for a MEDICALLY NECESSARY service or supply incurred while the COVERED PERSON is eligible for benefits under this Plan and incurred for a service of supply that is not excluded for benefit coverage.

AMBULATORY SURGICAL CENTER

An institution or facility, either free-standing or as part of a HOSPITAL, with permanent facilities, equipped and operated for the primary purpose of performing SURGICAL PROCEDURES and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a PHYSICIAN for the practice of medicine or dentistry or for the primary purpose of performing terminations of PREGNANCY shall not be considered to be an AMBULATORY SURGICAL CENTER.

AMENDMENT

A formal document that changes the provisions of the Plan Document, duly authorized, and signed by the PLAN ADMINISTRATOR.

BENEFIT PERCENTAGE

In accordance with the coverage provisions as stated in the Plan, that portion of ELIGIBLE EXPENSES to be paid by the Plan. It is the primary basis used to determine any out-of-pocket expenses in excess of the annual DEDUCTIBLE which are to be paid by the COVERED EMPLOYEE and/or RETIRED EMPLOYEE. It is the only the part of any claim that the plan must pay, and the rest is the EMPLOYEE'S responsibility after DEDUCTIBLES, COPAYMENT, contracted expense reductions for networks, etc.

BENEFIT PERIOD

A time period of one CALENDAR YEAR. Such BENEFIT PERIOD will terminate on the earliest of the following dates:

1. The last day of the one-year period so established;
2. The day the maximum benefit applicable to the COVERED PERSON becomes payable.

BIRTHING CENTER

Any free-standing health facility, place, professional office, or institution which is not a HOSPITAL or in a HOSPITAL, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the law pertaining to BIRTHING CENTERS in the jurisdiction where the facility is located.

The BIRTHING CENTER must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a PHYSICIAN and either a REGISTERED NURSE (R.N.) or a licensed nurse-midwife; and have a written agreement with a HOSPITAL in the same

locality for immediate acceptance of patients who develop complications or require pre- or post- delivery CONFINEMENT.

BRAND NAME DRUG

BRAND NAME DRUG means a trade name medication.

CALENDAR YEAR

A period of time commencing on January 1 and ending on December 31 of the same year.

CERTIFIED COUNSELOR

An individual qualified by education, training, and experience to provide counseling in relation to emotional disorders, psychiatric conditions, or SUBSTANCE ABUSE.

CHIROPRACTOR TREATMENT

Services performed by a person trained and licensed to practice chiropractic medicine, provided those services are for the remedy of diseases or conditions which the chiropractor is licensed to treat.

CLAIM DETERMINATION PERIOD

A CALENDAR YEAR or that portion of a CALENDAR YEAR during which the individual for whom claim is made has been covered under this Plan.

CLAIMS ADMINISTRATOR

The person or firm employed by the COMPANY to provide administrative, clerical, and consulting services to the COMPANY in connection with the operation of the Plan and to provide any other functions, including the processing and payment of claims.

CLOSE RELATIVE

The spouse, parent, brother, sister, or child of the COVERED PERSON, whether the relationship is by blood or exists in law.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE

This is the COVERED PARTICIPANT'S share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, a COINSURANCE payment of 20% would be \$200. This may change if the COVERED PARTICIPANT has not met their **DEDUCTIBLE**.

COMPANY

The City of Franklin

COMPLICATIONS OF PREGNANCY

COMPLICATIONS OF PREGNANCY means:

1. MEDICAL CONDITIONS that are distinct from PREGNANCY, but adversely affected by PREGNANCY or caused by PREGNANCY. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A non-elective cesarean section surgical procedure;
3. A terminated ectopic PREGNANCY; or

4. A spontaneous termination of PREGNANCY that occurs during a gestation in which a viable birth is not possible.

COMPLICATIONS OF PREGNANCY does not mean: false labor, occasional spotting, prescribed rest during the PREGNANCY; or similar conditions associated with the management of a difficult PREGNANCY, but not constituting a distinct medical diagnosis.

CONFINEMENT

CONFINEMENT means being a resident patient in a HOSPITAL for at least 15 consecutive hours per day or being a resident bed patient in a SKILLED NURSING FACILITY or other qualified treatment facility 24 hours a day. Successive CONFINEMENTS are considered one if:

1. Due to the same INJURY or SICKNESS; and
2. Separated by fewer than 100 consecutive days when the COVERED PERSON is not confined.

CONVALESCENT PERIOD

A period of time commencing with the date of CONFINEMENT by a COVERED PERSON in a Skilled Nursing or Extended Care Facility. A CONVALESCENT PERIOD will terminate when the COVERED PERSON has been free of CONFINEMENT in any and all institutions providing HOSPITAL or nursing care for a period of thirty (30) consecutive days. A new CONVALESCENT PERIOD shall not commence until a previous CONVALESCENT PERIOD has terminated.

COPAYMENT

An amount of money that is paid each time a particular service is used.

COSMETIC DENTISTRY

COSMETIC DENTISTRY means dentally unnecessary procedures.

COSMETIC PROCEDURE

Any procedure performed primarily:

1. to improve physical appearance; or
2. to treat a mental disorder through a change in bodily form; or
3. to change or restore bodily form without correcting or materially improving a bodily function.

COVERED EMPLOYEE

Any EMPLOYEE meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED MEDICAL EXPENSES

Services and supplies which are not specifically excluded from coverage under this Plan and are MEDICALLY NECESSARY to treat INJURY or SICKNESS.

COVERED PERSON

Any EMPLOYEE, retiree, or dependent meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE

CREDITABLE COVERAGE includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or MEDICARE.

CREDITABLE COVERAGE does not include coverage consisting solely of dental or vision benefits.

CUSTODIAL CARE

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a COVERED PERSON, whether or not TOTALLY DISABLED, in the activities of daily living. Such activities include, but are not limited to the following: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

A specified dollar amount of covered expenses which must be incurred by the COVERED PERSON during a BENEFIT PERIOD before any other covered expenses to which a DEDUCTIBLE applies can be considered for payment according to the applicable BENEFIT PERCENTAGE.

DEFRA

The Deficit Reduction Act of 1984, as amended.

DENTIST

An individual who is duly licensed to practice dentistry or oral surgery in the state where the dental service is performed and who is operating within the scope of his license.

DEPENDENT COVERAGE

Eligibility under the terms of the Plan for benefits payable as a consequence of ELIGIBLE EXPENSES incurred for a SICKNESS or INJURY of a dependent.

DURABLE MEDICAL EQUIPMENT

Equipment prescribed by the attending PHYSICIAN which meets all of the following requirements: 1) it is MEDICALLY NECESSARY; 2) it can withstand repeated use; 3) it is not disposable; 4) it is not useful in the absence of a SICKNESS or INJURY; 5) it would have been covered if provided in a HOSPITAL; and 6) it is appropriate for use in the home.

EDUCATIONAL INSTITUTION

An institution accredited in the current publication of accredited institutions of higher education including vocational technical schools.

ELIGIBLE EXPENSE

Any MEDICALLY NECESSARY treatment, service, or supply that is not specifically excluded from coverage elsewhere in this Plan.

ELIGIBLE PROVIDER

ELIGIBLE PROVIDERS shall include the following legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered ELIGIBLE EXPENSES under the Plan:

- Acupuncturist (for use as anesthesia only)
- AMBULATORY SURGICAL CENTER
- Audiologist (MS)
- BIRTHING CENTER
- CERTIFIED COUNSELOR under the supervision of an M.D., D.O., or Ph.D.
- Certified REGISTERED NURSE Anesthetist
- Chiropractor

- Clinic
- DENTIST
- Dialysis Center
- Home Health Agency
- HOSPICE
- HOSPITAL
- Laboratory
- LICENSED PRACTICAL NURSE
- Licensed Vocational Nurse
- Medical Supply Purveyor
- Midwife
- Nurse Practitioner
- OCCUPATIONAL THERAPIST
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath
- OUTPATIENT PSYCHIATRIC TREATMENT FACILITY
- OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY
- Pharmacy/Pharmacist
- Physical Therapist
- PHYSICIAN (M.D.)
- PHYSICIAN'S Assistant
- Podiatrist
- Professional ambulance service
- Psychiatrist
- PSYCHOLOGIST
- Registered Dietitian
- REGISTERED NURSE
- SKILLED NURSING FACILITY
- SOCIAL WORKER under the supervision of an M.D., D.O., or Ph.D.
- SPEECH THERAPIST

"ELIGIBLE PROVIDER" shall not include the COVERED PERSON or any CLOSE RELATIVE of the COVERED PERSON.

EMPLOYEE

An active EMPLOYEE of the COMPANY receiving compensation from the COMPANY for services rendered to the COMPANY. EMPLOYEE means a person who is in an EMPLOYER-EMPLOYEE relationship with the COMPANY and who is classified by the COMPANY as a regular EMPLOYEE. The term EMPLOYEE does not include any EMPLOYEE covered by a collective bargaining agreement that specifically does not provide for coverage under the Plan, provided that health care benefits were the subject of good faith bargaining between the EMPLOYEE'S bargaining representative and the COMPANY. The term EMPLOYEE does not include an employee classified by the COMPANY as a temporary, emergency, part-time, or seasonal employee.

EMPLOYEE COVERAGE

Coverage hereunder providing benefits payable as a consequence of an INJURY or SICKNESS of an EMPLOYEE.

EMPLOYER

The City of Franklin

ENROLLMENT DATE

ENROLLMENT DATE, within the meaning of HIPAA, as defined by the Department of Labor is the first day of coverage. If there is a Waiting Period, it is the first day of the Waiting Period.

EXPENSES INCURRED

The charges generated by the service or treatment completed by the provider, often used when referring of the date the services were provided.

EXPERIMENTAL

Services, supplies, care, procedures, treatment, technology, drugs, or research studies which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

FAMILY UNIT

A COVERED EMPLOYEE and/or RETIRED EMPLOYEE and his eligible dependents.

FAMILY AND MEDICAL LEAVE ACT

A Federal law, effective August 5, 1993, applying to EMPLOYERS with fifty (50) or more EMPLOYEES, and applicable State law, as may be amended from time to time.

FIDUCIARY

The City of Franklin, which has the authority to control and manage the operation and administration of this Plan.

FORMULARY

A list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan as amended from time to time. Please refer to Schedule of Prescription Drug Benefits for which tier is considered Formulary.

FOSTER CHILD

A child who is being raised as the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S child. The child must depend on the COVERED EMPLOYEE and/or RETIRED EMPLOYEE for primary support and must live in the home of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and the COVERED EMPLOYEE and/or RETIRED EMPLOYEE may legally claim the child as a Federal income tax deduction.

A covered FOSTER CHILD, for the purpose of this Plan, does not include a child temporarily living in the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S home, a child placed in the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S home by a social service agency which retains control of the child; or a child whose natural parent(s) may exercise or share parental responsibility and control.

FULL-TIME WORK

An EMPLOYEE who works for the COMPANY on a REGULAR BASIS on an average of at least 20 hours per week. Such work may occur either at the usual place of business of the COMPANY or at a location to which the business of the COMPANY requires the EMPLOYEE to travel and for which he receives regular earnings from the COMPANY.

GENERIC DRUG

GENERIC DRUG means a PRESCRIPTION DRUG which has the equivalency of the BRAND NAME DRUG with the same intended therapeutic use and metabolic disintegration. This Plan will consider as a GENERIC DRUG any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

GENETIC INFORMATION

Information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

HOME HEALTH CARE AGENCY

A MEDICARE-approved public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must be primarily engaged in and duly licensed by the appropriate licensing authority (if such licensing is required) to provide skilled nursing services and other therapeutic services. It must have policies established by a professional group associated with the agency or organization, including at least one PHYSICIAN and at least one REGISTERED NURSE (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a PHYSICIAN or REGISTERED NURSE. Its staff must maintain a complete medical record on each individual, and it must have a full-time administrator.

HOME HEALTH CARE PLAN

A program for continued care and treatment of the COVERED PERSON established and approved in writing by the COVERED PERSON'S attending PHYSICIAN, which must be reviewed by the physician at least every 30 days. The attending PHYSICIAN must certify that the proper treatment of the SICKNESS or INJURY would require continued CONFINEMENT as a resident inpatient in a HOSPITAL or extended care facility in the absence of the services and supplies provided as part of the HOME HEALTH CARE PLAN.

HOME HEALTH CARE SERVICES AND SUPPLIES

HOME HEALTH CARE SERVICES AND SUPPLIES includes: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a HOME HEALTH CARE AGENCY (this does not include general housekeeping services); PHYSICAL, OCCUPATIONAL and SPEECH THERAPY; medical supplies; and laboratory services by or on behalf of the HOSPITAL.

HOSPICE

A health care program providing a coordinated set of services rendered at home, in OUTPATIENT settings, or in institutional settings for COVERED PERSONS suffering from a condition that has a terminal prognosis and who are expected to die within six months. A HOSPICE must have an interdisciplinary group of personnel which includes at least one PHYSICIAN and one REGISTERED NURSE, and its staff must maintain central clinical records on all patients. A HOSPICE must meet the standards of the National HOSPICE Organization (NHO) and applicable state licensing and must be duly licensed by the applicable licensing authority. Also, used to refer to the facility providing the HOSPICE program or services.

HOSPITAL

An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to an ill or injured person on an inpatient basis at the patient's expense.
2. It is constituted, licensed, and operated in accordance with the laws of the jurisdiction in which it is located and which pertain to HOSPITALS.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of a SICKNESS or an INJURY.
4. It provides such treatment for compensation by or under the supervision of PHYSICIANS, with continuous twenty-four (24) hour nursing services by REGISTERED NURSES (R.N.'s).
5. It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO), the American Osteopathic Association, or the Healthcare Facilities Accreditation Program authorized by the Centers for Medicare and Medicaid Services. The JCAHCO accreditation limitation may be waived at the discretion of the Plan if the only HOSPITAL in the immediate area is not JCAHCO approved.
6. It is a provider of services under MEDICARE.
7. It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "HOSPITAL" will also include an institution qualified and operating legally for the treatment of psychiatric problems, SUBSTANCE ABUSE, or tuberculosis that does not have surgical facilities and/or is not approved by MEDICARE, provided that such institution satisfies the definition of HOSPITAL in all other respects.

HOSPITAL MISCELLANEOUS EXPENSES

The actual charges made by a HOSPITAL in its own behalf for services and supplies rendered to the COVERED PERSON which are MEDICALLY NECESSARY for the treatment of such COVERED PERSON. HOSPITAL MISCELLANEOUS EXPENSES do not include charges for ROOM AND BOARD or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the HOSPITAL or otherwise.

ILLNESS

A bodily disorder, disease, physical SICKNESS, mental infirmity, or functional nervous disorder of a COVERED PERSON. A recurrent SICKNESS will be considered one SICKNESS. Concurrent SICKNESSES will be considered one SICKNESS unless the concurrent SICKNESSES are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one SICKNESS. For the purposes of this plan, a PREGNANCY shall be treated as and covered as a service.

INJURY

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

INPATIENT CARE

HOSPITAL ROOM AND BOARD and general nursing care for a person confined in a HOSPITAL or extended care facility as a bed patient.

INTENSIVE CARE UNIT (ICU)

An area within a HOSPITAL which is reserved, equipped, and staffed by the HOSPITAL for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

INVESTIGATIONAL (See Experimental)

LATE ENROLLEE

An individual who is enrolled for coverage after the initial eligibility date described in the section entitled Late Enrollment. Note, however, a SPECIAL ENROLLEE shall not be considered a LATE ENROLLEE hereunder.

LEGAL GUARDIAN

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

LICENSED PRACTICAL NURSE (L.P.N.)

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MEDICAL CARE FACILITY

A HOSPITAL, or a facility that treats one or more specific INJURY, ILLNESS or SICKNESS or any type of Skilled Nursing or Extended Care Facility.

MEDICAL CONDITION

MEDICAL CONDITION means a syndrome or group of symptoms that are not attributable to a specific disease or distinct medical diagnosis.

MEDICAL EMERGENCY

See VALID MEDICAL EMERGENCY

MEDICALLY NECESSARY/DENTALLY NECESSARY

The service a patient receives which is recommended by a PHYSICIAN and is required to treat the symptoms of a certain INJURY, ILLNESS or SICKNESS. The care or treatment 1) must be consistent with the diagnosis and prescribed course of treatment for the COVERED PERSON'S condition; 2) must be required for reasons other than the convenience of the COVERED PERSON or the attending PHYSICIAN; 3) is generally accepted as an appropriate form of care for the condition being treated; and 4) is likely to result in physical improvement of the patient's condition which is unlikely to ever occur if the treatment is not administered. Therefore, although a service may be prescribed by a PHYSICIAN, it does not mean the service is MEDICALLY NECESSARY. The PLAN ADMINISTRATOR has the discretionary authority to decide whether care or treatment is MEDICALLY NECESSARY/DENTALLY NECESSARY.

MEDICARE

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

MINOR EMERGENCY MEDICAL CLINIC (See Urgent Care)

MISCELLANEOUS HOSPITAL SERVICES

The actual charges made by a HOSPITAL, other than ROOM AND BOARD, on its own behalf for services and supplies rendered to the COVERED PERSON, on an inpatient or OUTPATIENT basis, which are MEDICALLY NECESSARY for the treatment of such COVERED PERSON. This includes HOSPITAL admission kits, but all other personal or convenience items are excluded.

NEGOTIATED FEE

This is the amount agreed upon between the provider and the Preferred Provider Organization, regarding the fee the provider should be reimbursed. As part of participating in the Preferred Provider Network the

provider has agreed to reduce their fees for Network participants.

NEWBORN

An infant from the date of birth until the mother is discharged from the HOSPITAL.

NO-FAULT AUTO INSURANCE

The basic reparations provision of the law providing for payments without determining fault in connection with automobile accidents.

OBRA

The Omnibus Budget Reconciliation Act of 1993, as amended from time to time.

OCCUPATIONAL THERAPIST

A licensed practitioner who treats, primarily, the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

OUTPATIENT

The classification of a COVERED PERSON when that COVERED PERSON receives medical care, treatment, services, or supplies at a clinic, a PHYSICIAN'S office, a HOSPITAL if not a registered bed patient at that HOSPITAL, an OUTPATIENT PSYCHIATRIC TREATMENT FACILITY, or an OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY.

OUTPATIENT PSYCHIATRIC TREATMENT FACILITY

An administratively distinct governmental, public, private or independent unit or part of such unit that provides OUTPATIENT mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility and who assumes the overall responsibility for coordinating the care of all patients.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY

An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or SUBSTANCE ABUSE; provides detoxification services needed with its effective treatment program; provides infirmity-level medical services that may be required; is at all times supervised by a staff of PHYSICIANS; prepares and maintains a written plan of treatment for each patient, based on the patient's medical, psychological, and social needs and supervised by a PHYSICIAN; and meets licensing standards.

OUTPATIENT SURGERY

OUTPATIENT SURGERY includes, *but is not limited to*, the following types of procedures performed in a HOSPITAL without a pre-certified or pre-scheduled overnight stay or surgi-center:

1. Operative or cutting procedures for the treatment of a SICKNESS or INJURY;
2. The treatment of fractures and dislocations; or
3. Endoscopic or diagnostic procedures such as biopsies, cystoscopy, bronchoscopy, and angiocardiology.

PHYSICAL THERAPIST

A licensed practitioner who treats patients by means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises. Where there is no licensure law, the PHYSICAL THERAPIST must be certified by the appropriate professional body.

PHYSICIAN

A legally-licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical PSYCHOLOGIST to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A PHYSICIAN shall not include the COVERED PERSON or any CLOSE RELATIVE of the COVERED PERSON.

PLAN ADMINISTRATOR

The COMPANY responsible for the management of the Plan and having the authority to control and manage the operation and administration of the Plan as set forth within the Plan (see, for example, "Responsibilities For Plan Administration").

The PLAN ADMINISTRATOR may employ persons or firms to process claims and perform other Plan-connected services. The PLAN ADMINISTRATOR is the named PLAN ADMINISTRATOR within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended.

PLAN YEAR

This Plan recognizes PLAN YEAR as January 1st through December 31st.

PREDETERMINATION

PREDETERMINATION means a review by the Plan of a DENTIST'S planned treatment and expected charges. The review will include review of diagnostic charges performed prior to the actual services.

PREGNANCY

That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state. For the purposes of this plan, a PREGNANCY shall be treated as and covered as a service.

PRESCRIPTION DRUG

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed PHYSICIAN. Such drug must be MEDICALLY NECESSARY in the treatment of a SICKNESS or INJURY.

In regards to drugs and drug therapies newly approved by the U.S. Food and Drug Administration (FDA) and available to the consumer market after the Summary Plan Descriptions have been distributed, the Plan reserves the right to:

- extend coverage to medications that have recently met the FDA guidelines;
- assign a unique co-payment or COINSURANCE to new drugs entering the market;
- limit quantities of new lifestyle-type drugs entering the market; and
- add drugs to the exclusion list if the FDA has issued a warning or a recall, voluntary or otherwise, to the consumer market.

COVERED PERSON(s) will receive notices regarding any Plan modifications regarding drugs or therapies at such time that they present a prescription for drugs or drug therapies impacted by modifications to the Plan. Participating pharmacies are charged to communicate any updates or changes to the Plan pharmacy program which impact a participant.

PREVENTIVE CARE

Medical treatment, services or supplies rendered solely for the purpose of maintaining health and not for the treatment of an INJURY or SICKNESS. When a claim is submitted, the PHYSICIAN'S office must code the claim to indicate PREVENTIVE CARE or this Plan will consider the claim as treatment of an INJURY or SICKNESS.

PRIMARY PLAN

A plan whose allowable benefits are not reduced by those of another plan.

PRIVATE DUTY NURSE

A PRIVATE DUTY NURSE is a nurse who cares for a patient on a fee-for-service basis. The PRIVATE DUTY NURSE may or may not provide the care in an institution or at home, but is typically not providing nursing services as a member of the institution staff when in this role.

PSYCHIATRIC CARE

The term "PSYCHIATRIC CARE," also known as psychoanalytic care, means treatment for a psychiatric condition, a mental SICKNESS or disorder, a functional nervous disorder, alcoholism, or drug addiction. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic depression.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In order to meet the definition of a QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO), a court order or divorce decree must contain all of the following information:

1. The EMPLOYEE'S name and last known address.
2. The dependent's full name and address.
3. A reasonable description of the coverage to be provided or the manner in which coverage will be established, i.e. through the EMPLOYER.
4. The period for which coverage must be provided.
5. The order or decree must specifically name the COMPANY as a source of coverage.

A National Medical Support notice will also meet the definition of a QMCSO.

A QMSCO cannot require the Plan to provide any type of or form of benefit, or any other option, not otherwise available under the Plan except to the extent mandated by Section 1908 of the Social Security Act.

REGISTERED NURSE (R.N.)

An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

REGULAR BASIS

A basis whereby a COVERED EMPLOYEE and/or RETIRED EMPLOYEE is regularly at work as shown in the section titled Eligibility. Such work may occur either at the usual place of business of the COMPANY or at a location to which the business of the COMPANY requires the COVERED EMPLOYEE and/or RETIRED EMPLOYEE to travel and for which he or she receives regular earnings from the COMPANY.

RETIRED EMPLOYEE

A RETIRED EMPLOYEE is a former Active EMPLOYEE of the EMPLOYER that elects to contribute to the Plan the required contribution(s) and who was retired while employed by the EMPLOYER and met the criteria for Plan participation established by the provisions of the EMPLOYER'S relevant policy or relevant collective bargaining agreement.

REVIEW ORGANIZATION

The organization contracting with the COMPANY to perform cost containment services.

ROOM AND BOARD

All charges, by whatever name called, which are made by a HOSPITAL, HOSPICE, or extended care facility as a condition of occupancy. Such charges do not include the professional services of PHYSICIANS nor intensive nursing care (by whatever name called).

SEMI-PRIVATE

A class of accommodations in a HOSPITAL or extended care facility in which at least two patient beds are available per room.

SICKNESS

Please see definition of ILLNESS.

SKILLED NURSING FACILITY

An institution, or distinct part thereof, operated pursuant to law and which meets all of the following conditions:

1. It is licensed to provide and is engaged in providing, on an inpatient basis for persons convalescing from INJURY or SICKNESS, professional nursing services rendered by a REGISTERED NURSE (R.N.), LICENSED PRACTICAL NURSE (L.P.N.) or Licensed Vocational Nurse (L.V.N.) under the direction of a REGISTERED NURSE and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a PHYSICIAN or REGISTERED NURSE.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time REGISTERED NURSE.
4. Its staff maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of MENTAL DISORDERS.
7. It is approved and licensed by MEDICARE.

SOCIAL WORKER

An individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions; or SUBSTANCE ABUSE.

SPECIAL ENROLLEE

An EMPLOYEE or dependent who is entitled to and who requests Special Enrollment within thirty-one (31) days of losing other health coverage or a newly acquired dependent for whom coverage is requested within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption.

SPEECH THERAPIST

An individual who is skilled in the treatment of communication and swallowing disorders due to SICKNESS, INJURY or birth defect, is a member of the American Speech and Hearing Association, has a Certificate of Clinical Competence, and is licensed in the state in which services are provided.

SUBSTANCE ABUSE

Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

SURGICAL PROCEDURES

Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocation, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopies, or injection of sclerosing solution by a licensed PHYSICIAN.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

TEMPOROMANDIBULAR JOINT SYNDROME

Treatment of Jaw Joint Disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

THERAPY SERVICES

Services or supplies used for the treatment of a SICKNESS or INJURY to promote the recovery of a COVERED PERSON. THERAPY SERVICES are covered to the extent specified in the Plan and may include:

1. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
2. Dialysis Treatments - the treatment of acute or chronic kidney disease which may include the supportive use of an artificial kidney machine.
3. Occupational Therapy - treatment of the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.
4. Physical Therapy.
5. Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
6. Respiration Therapy - introduction of dry or moist gases into the lungs for treatment purposes.
7. Speech Therapy - treatment of communication and swallowing disorders due to a SICKNESS, INJURY or birth defect.

TOTAL DISABILITY (TOTALLY DISABLED)

A physical state of a COVERED PERSON resulting from a SICKNESS or INJURY which wholly prevents:

1. A COVERED EMPLOYEE and/or RETIRED EMPLOYEE from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
2. A dependent from performing the normal activities of a person of like age and sex and in good health.

TRANSITIONAL TREATMENT

An OUTPATIENT program specifically designed for the diagnosis or active treatment of a Mental

Disorder or SUBSTANCE ABUSE when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial HOSPITAL services, if required by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four (4) hours, a day and no charge is made for ROOM AND BOARD.

URGENT CARE CLINIC

A free-standing facility or the portion of a HOSPITAL facility with a specifically designed URGENT CARE ROOM, which is engaged primarily in providing minor emergency and episodic medical care to a COVERED PERSON. A board-certified PHYSICIAN, a REGISTERED NURSE, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system.

URGENT CARE ROOM

A HOSPITAL billed room that is used for treating conditions of lesser severity than would be needed with an Emergency Room (e.g. Revenue Code 456).

USUAL AND CUSTOMARY (U&C)

The term "USUAL AND CUSTOMARY" refers to the designation of a charge as being the usual charge made by a PHYSICIAN or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise. The PLAN ADMINISTRATOR has the final and discretionary authority to determine the USUAL AND CUSTOMARY fee.

VALID MEDICAL EMERGENCY

A VALID MEDICAL EMERGENCY is an INJURY or SICKNESS that would jeopardize or impair the health of the COVERED PERSON if not treated immediately. Examples of a VALID MEDICAL EMERGENCY are conditions that manifest themselves by acute symptoms of severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. Placing the health of the individual in serious jeopardy;
- b. Serious impairment of bodily functions; or
- c. Serious dysfunction of any bodily organ or part.

WELL-CARE

The term "WELL-CARE" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and *not* for the treatment of a SICKNESS or INJURY. This includes pediatric preventive services, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the child as defined by standards of Child Health Care issued by the American Academy of Pediatrics.

GENERAL PROVISIONS

Notice of Claim

Written Notice of Claim should be submitted to the CLAIMS ADMINISTRATOR within ninety (90) days after the occurrence. All claims must be filed within twelve (12) months or payment will be denied. Written notice of claim given by or on behalf of the COVERED PERSON to the CLAIMS ADMINISTRATOR, with information sufficient to identify the COVERED PERSON, will be considered notice.

Failure to furnish proof within the time provided in the Plan will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Claims Procedure

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the PLAN ADMINISTRATOR.

The definitions of the types of claims are as follows:

Urgent Care Claim

A claim involving urgent care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant (including where such delay could significantly prolong a recovery period or lead to requiring more serious or complex medical treatment); or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting PHYSICIAN, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A PHYSICIAN with knowledge of the claimant's MEDICAL CONDITION may determine if a claim is one involving urgent care. If there is no such PHYSICIAN, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a claim involving urgent care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
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Insufficient information on the claim, or failure to follow the Plan's procedure for filing a claim:

Notification to claimant, orally or in writing	24 hours
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Response by claimant, orally or in writing	48 hours
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Benefit determination, orally or in writing	48 hours
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Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
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Determination as to extending course of treatment	24 hours
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If there is an adverse benefit determination on a claim involving urgent care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, claims subject to pre-certification. Please see the Managed Care section of this booklet for further information about Pre-Service claims.

In the case of a Pre-Service claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
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Extension due to matters beyond the control of the Plan	15 days
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Insufficient information on the claim:

Notification of	15 days
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Response by claimant	45 days
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Notification, orally or in writing, of failure to follow the Plan's procedures for filing a claim	5 days
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Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
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Request to extend course of treatment	15 days
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Review of adverse benefit determination	30 days
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Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service claim means any claim for a Plan benefit that is not a claim involving urgent care or a Pre-Service claim, in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	60 days

Notice to Claimant of Adverse Benefit Determination

Except with urgent care claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the PLAN ADMINISTRATOR shall cause written or electronic notification of any adverse benefit determination to be provided. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline,

protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

7. If the adverse benefit determination is based on the MEDICAL NECESSITY or EXPERIMENTAL or INVESTIGATIONAL treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Internal Appeals Program

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the claim to the PLAN ADMINISTRATOR for appeal. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance or non-compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appointed fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical review, including determinations with regard to whether a particular treatment, drug, or other item is EXPERIMENTAL, INVESTIGATIONAL, or NOT MEDICALLY NECESSARY or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. The health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

External Appeals Program

In case of an internal appeal denial, a claimant then has the right to request that the appeal advance to an independent third party reviewer, which right is limited to external appeals as required by the Patient Protection and Affordable Care Act. A claimant may submit written comments, documents, records, and other information relating to the claim that was denied.

The following standards apply to the External Appeal process:

1. External review of plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
2. Clear information about their right to both internal and external appeals – both in the standard plan materials, and at the time the Company denies a claim.
3. Expedited access to external review in some cases – included emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
4. Cost of this independent external appeal will be covered through the plan.
5. Review by an independent third party. Reviewers must meet certain standards, keep written records, and are not affected by conflicts of interest.
6. Expedited processes for urgent claims, and a process for EXPERIMENTAL or INVESTIGATIONAL treatment.
7. Final decision of the independent third party is binding. The PLAN ADMINISTRATOR will coordinate the selection of the independent third party reviewer.

A claimant can, upon request, receive culturally and linguistically detailed information about the grounds for the denial of claims or coverage through the appeal process for this claim.

Please note that all appeals are subject to the deadlines and timeframes for consideration as outlined in the plan document and under the applicable regulations.

Proof of Loss

The PLAN ADMINISTRATOR will have the right and opportunity to have examined any individual whose INJURY or SICKNESS is the basis of a claim hereunder when and as often as it may reasonably require during the dependency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Choice of PHYSICIAN

The COVERED PERSON will have free their choice of any legally qualified PHYSICIAN or surgeon, and the PHYSICIAN-patient relationship will be maintained. Choice of PHYSICIAN or surgeon, however, may impact the coverage level provided by the Plan.

Payment of Claims

All Plan benefits are payable to the provider of service, or subject to written direction of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE. All or a portion of any payments provided by the Plan on account of HOSPITAL, nursing, medical or surgical services may, at the COVERED EMPLOYEE'S and/or RETIRED EMPLOYEE'S option and unless the COVERED EMPLOYEE and/or RETIRED EMPLOYEE requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the HOSPITAL or person rendering such services; however, if any such benefit remains unpaid at the death of the COVERED EMPLOYEE and/or RETIRED EMPLOYEE or if the participant is a minor or is, in the opinion of the PLAN ADMINISTRATOR, legally incapable of giving a valid receipt and discharge for any payment, the PLAN ADMINISTRATOR may, at its option, pay such benefits to the estate or to anyone or more of the following relatives of the wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.

Assignment and Assignability

Benefits may not be assigned except by consent of the PLAN ADMINISTRATOR, other than to providers of medical services and according to the provisions set forth in the Plan. Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no amount payable at anytime hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts and/or liabilities of any person entitled to any amount payable under the Plan or any part thereof.

Rights of Recovery

Whenever payments have been made by the COMPANY with respect to ALLOWABLE EXPENSES in excess of the maximum amount of payment necessary to satisfy the intent of this Plan or when the COVERED PERSON has not cooperated with the Plan or has done something to compromise the Plan's rights or has refused to reimburse the Plan from any recoveries, the COMPANY will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future benefits to offset for such excess payments. In addition, the COMPANY has the right to recoup benefits from providers and the providers may hold the COVERED PERSON personally liable.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Legal Proceedings

No action at law or in equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

Conformity with Governing Law

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

Time Limitation

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss or the bringing of an action at law or in equity is less than that permitted under the guidelines of any Federally mandated law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Statements

All statements made by the COMPANY or by a COVERED PERSON will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the COVERED PERSON.

Any COVERED PERSON who knowingly and with intent to defraud the Plan files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact commits a fraudulent act. The COVERED PERSON may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both. Additionally, commission of any such fraud or knowledge of may subject an Employee to termination as listed in the Termination of Coverage section.

Miscellaneous

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. pronouns used in this Plan shall be construed to include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural and/or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of this Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, the Plan, PLAN ADMINISTRATOR, Agent for the Service of Legal Process, Trustee, CLAIMS ADMINISTRATOR, and COMPANY will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

If an error should occur due to interpretation of benefits, inadvertent or otherwise, such error shall not create a past practice or establish a new benefit requirement for the Plan, and the CLAIMS ADMINISTRATOR, PLAN ADMINISTRATOR, OR COMPANY may correct benefits provided, including retroactively.

Payment for expenses in relation to services which are generally accepted as cost-containment measures in large claim management cases that are not normally covered under this Plan will be reimbursable upon recommendation of the CLAIMS ADMINISTRATOR and written approval by the PLAN ADMINISTRATOR. Pre-approval is recommended.

The Company reserves the right to obtain Stop-Loss Insurance to assist in funding the plan and in protecting the viability of the Plan. All Information available within the Plan may be used for Stop-Loss Insurance provided it is used in accordance with the law.

Permitted and Required Uses of Protected Health Information

PLAN ADMINISTRATOR'S Certification of Compliance

Neither the Health Plan nor any business associate servicing the Plan will disclose Plan enrollees' protected health information to the PLAN ADMINISTRATOR unless the PLAN ADMINISTRATOR certifies that the Plan's Plan Document has been amended to incorporate this section and agrees to abide by this section.

Purpose of Disclosure to PLAN ADMINISTRATOR

The Plan and any business associate servicing the Plan will disclose Plan enrollees' protected health information to the PLAN ADMINISTRATOR only to permit the PLAN ADMINISTRATOR 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 implementing regulations (45 C.R.R. Parts 160-64). Any disclosure to and use by the PLAN ADMINISTRATOR of Plan enrollees' protected health information will be subject to and consistent with the provisions of restrictions on PLAN ADMINISTRATOR'S Use and Disclosure of Protected Health Information and adequate separation between the PLAN ADMINISTRATOR and the Plan of this section.

Neither the Plan nor any business associate servicing the Plan will disclose Plan enrollees' protected health information to the PLAN ADMINISTRATOR unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Enrollees.

Restrictions on PLAN ADMINISTRATOR'S Use and Disclosure of Protected Health Information

The PLAN ADMINISTRATOR will neither use nor further disclose Plan enrollees' protected health information, except as permitted or required by the Plan's Plan Document, as amended, or required by law.

The PLAN ADMINISTRATOR will ensure that any agent, including any subcontractor, to whom it provides Plan enrollees' protected health information agrees to the restrictions and conditions of the Plan, including this section, with respect to Plan enrollees' protected health information.

The PLAN ADMINISTRATOR will not use or disclose Plan enrollees' protected health information for employment-related actions or decisions or in connection with any other benefits or COVERED EMPLOYEE and/or RETIRED EMPLOYEE benefit plan of the PLAN ADMINISTRATOR.

The PLAN ADMINISTRATOR will report to the Plan any use or disclosure of Plan enrollees' protected health information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

The PLAN ADMINISTRATOR will make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations §164.524.

The PLAN ADMINISTRATOR will make Plan enrollees' protected health information available for AMENDMENT, and will on notice amend Plan enrollees' protected health information, in accordance with 45 Code of Federal Regulations § 164.526.

The PLAN ADMINISTRATOR will track disclosures it may make of Plan enrollees' protected health information 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.

The PLAN ADMINISTRATOR will make its internal practices, books, and records, relating to its use and disclosure of Plan enrollees' protected health information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

The PLAN ADMINISTRATOR will, if feasible, return or destroy all Plan enrollees' protected health information, in whatever form or medium, received from the Plan when the Plan enrollees' 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 enrollees' protected health information, the PLAN ADMINISTRATOR will limit the use or disclosure of any Plan enrollees' protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation between the PLAN ADMINISTRATOR and the Plan

The following EMPLOYEES and/or RETIRED EMPLOYEES or classes of EMPLOYEES or other workforce members under the control of the PLAN ADMINISTRATOR may be given access to Plan enrollees' protected health information received from the Plan:

- Director of Administration
- HR Coordinator
- Director of Finance/Treasurer
- Assistant Finance Director
- Accounting Clerk

This list includes every COVERED EMPLOYEE and/or RETIRED EMPLOYEE or class of EMPLOYEES or other workforce members under the control of the PLAN ADMINISTRATOR who may receive Plan enrollees' 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 and/or RETIRED EMPLOYEES, classes of EMPLOYEES or other workforce members identified in the list above will have access to Plan enrollees' protected health information only to perform the plan administration functions that the PLAN ADMINISTRATOR provides for the Plan.

The EMPLOYEES and/or RETIRED 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 ADMINISTRATOR, for any use or disclosure of Plan enrollees' protected health information in breach or violation of or noncompliance with the provisions of this section to the Plan's Plan Document.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. An individual may be appointed by City of Franklin to be PLAN ADMINISTRATOR and serve at the convenience of the City as the plan sponsor. If the PLAN ADMINISTRATOR resigns, dies, or is otherwise removed from the position, City of Franklin shall appoint a new PLAN ADMINISTRATOR as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

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

PROCEDURE FOR RECEIPT OF QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO). Upon receipt of a Qualified Medical Child Support Order (QMCSO), the PLAN ADMINISTRATOR:

1. Will notify the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and alternative recipient (i.e., the child or the child's representative) of the Plan's receipt of the order and the Plan's procedures for determining whether the order is qualified;
2. Will determine whether the order is qualified within a reasonable period;
3. Will notify the COVERED EMPLOYEE and/or RETIRED EMPLOYEE and each alternative recipient of the determination; and
4. If the order is qualified, will administer the provision of benefits under such order.

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For COVERED EMPLOYEE and/or RETIRED EMPLOYEE and DEPENDENT COVERAGE: Funding is derived from the funds of the Employer and contributions made by the COVERED EMPLOYEES and/or RETIRED EMPLOYEES.

The level of any COVERED EMPLOYEE and/or RETIRED EMPLOYEE contributions will be set by the PLAN ADMINISTRATOR. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the CLAIMS ADMINISTRATOR.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a COVERED PERSON, if it is requested, the amount of overpayment will be deducted from future benefits payable.

HIPAA SECURITY STANDARDS

Definitions

Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Plan – The term "Plan" means The City of Franklin Employee Health and Welfare Benefit Non-grandfathered Plan Franklin, Wisconsin.

Plan Documents – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.*, the documents under which the group health plan was established and is maintained), including but not limited to The City of Franklin Employee Health and Welfare Benefit Non-Grandfathered Plan Franklin, Wisconsin.

Plan sponsor – The term "Plan Sponsor" means the entity as defined. The Plan sponsor is The City of Franklin.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use,

disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

WHEN WE WRITE THE RESOLUTION TO ADOPT THIS, HAVE THE COMMON COUNCIL SPECIFY THE AUTHORITY OF THE ADMINSTRATOR TO USE HIS DISCRETIONARY INTERPRETIVE AUTHORITY TO RESOLVE ANY CONFLICT BETWEEN THIS PLAN AND THE PRIOR LANGUAGE FOR ANY BODY CURRENTLY COVERED BY A LABOR CONTRACT AND TO INTERPRET THAT WITH CONSIDERATION TO THE PRIOR LANGUAGE. THIS GETS ME OUT OF HAVING TO ARGUE OVER ANY LANGUAGE CHANGE NOW, YET BE ABLE TO DEAL WITH ANY SPECIFIC PROBLEM THAT COMES UP!!!!

**THE CITY OF FRANKLIN
EMPLOYEE HEALTH AND WELFARE
NON-GRANDFATHERED PLAN**

Amendment #1

Effective January 1, 2012, The City of Franklin Employee Health and Welfare Non-Grandfathered Plan established January 1, 2002, restated January 1, 2003 and January 1, 2011 shall be amended as described herein.

With regards to the SCHEDULE OF MEDICAL BENEFITS – PLAN F789-17 (FORMERLY PLAN G) section on pages 9-13 of this Master Plan Document shall be renamed as PLAN F789-21 (FORMERLY PLAN G).

With regards to the SCHEDULE OF MEDICAL BENEFITS section on pages 9-13 of this Master Plan Document, Plan F789-19 (Formerly Plan D) shall be added as follows:

PLAN F789-19 (FORMERLY PLAN D)

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2012 (Includes all other Maximums)	\$1,250,000	
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2013 (Includes all other Maximums)	\$2,000,000	
MAXIMUM PLAN YEAR BENEFIT AMOUNT FOR 2014 (Includes all other Maximums)	Unlimited	
Note: The Network and Non-Network DEDUCTIBLE, Out-of-Pocket maximums and any other benefit maximums cross-satisfy one another.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per COVERED PERSON*	\$200	\$500
Per FAMILY UNIT*	\$600	\$1,500
*Note: The Plan will credit \$50 towards a COVERED PERSON'S DEDUCTIBLE for Inpatient HOSPITAL care or Inpatient surgery once per person in a CALENDAR YEAR.		

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
The DEDUCTIBLE does not apply to: <ul style="list-style-type: none"> • Network PREVENTIVE CARE; • Routine vision exam; • Routine Immunizations (to age 6); and • Ambulance charges; • Network Newborn charges; and • Health Risk Assessment 		
The following charges do not apply toward the DEDUCTIBLE: <ul style="list-style-type: none"> • Co-payments; • Cost containment penalties; and • Ineligible charges 		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Includes DEDUCTIBLE)		
The Out-of-Pocket is the amount paid by the COVERED PERSON in the CALENDAR YEAR. Charges noted below as not applying to the Out-of-Pocket do not calculate toward the Maximum Out-of-Pocket amount.		
Per COVERED PERSON	\$400	\$1,500
Per FAMILY UNIT	\$1,200	\$4,500
The Plan will pay the designated percentage of COVERED MEDICAL EXPENSES until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of COVERED MEDICAL EXPENSES for the rest of the CALENDAR YEAR unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: <ul style="list-style-type: none"> • Co-payments; • Cost containment penalties; and • Ineligible charges. 		
COVERED SERVICES		
Ambulance Service	90% DEDUCTIBLE waived	Paid at Network level
Ambulatory Surgery Center	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Autism Spectrum Disorders	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Chiropractic/SPINAL MANIPULATION	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Custom Molded Foot Orthotics	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Diabetic Supplies (see the PRESCRIPTION DRUG section for diabetic medications covered under the PRESCRIPTION DRUG Program)	90% after DEDUCTIBLE	70% after DEDUCTIBLE
DURABLE MEDICAL EQUIPMENT	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Health Risk Assessment	100% DEDUCTIBLE waived	
Home Health Care 40 visits per 12-months maximum	90% after DEDUCTIBLE	70% after DEDUCTIBLE
HOSPICE Care	90% after DEDUCTIBLE	70% after DEDUCTIBLE

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
HOSPITAL Billed Services		
Inpatient ROOM AND BOARD Limited to the SEMI-PRIVATE room rate	90% after DEDUCTIBLE	70% after DEDUCTIBLE
INTENSIVE CARE UNIT Limited to the HOSPITAL'S ICU Charge	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Inpatient Miscellaneous Charges	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT Emergency Room*	\$100 co-payment, then 90% after DEDUCTIBLE	Paid at Network level
*Note: For a VALID MEDICAL EMERGENCY only. See definition of VALID MEDICAL EMERGENCY as defined in the Definition section. The co-payment will be waived if COVERED PERSON is admitted to the HOSPITAL directly from the Emergency Room.		
OUTPATIENT Diagnostic Services	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT SURGERY Services	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT Other Services	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Jaw Joint/TMJ (Surgical and non-surgical treatment) \$1,250 CALENDAR YEAR maximum for non-surgical treatment	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Occupational Therapy (OUTPATIENT)	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Organ Transplants	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Other Covered Services	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT Private Duty Nursing	90% after DEDUCTIBLE	70% after DEDUCTIBLE
PSYCHIATRIC CARE- MENTAL DISORDERS and SUBSTANCE ABUSE		
Inpatient and TRANSITIONAL TREATMENT	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT	90% after DEDUCTIBLE	70% after DEDUCTIBLE
PHYSICIAN Services		
Inpatient visits	90% after DEDUCTIBLE	70% after DEDUCTIBLE
OUTPATIENT visits	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Emergency Room PHYSICIAN visit	90% after DEDUCTIBLE	Paid at Network level



	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
Office visits	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Surgery	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Allergy testing	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Allergy serum and injections	90% after DEDUCTIBLE	70% after DEDUCTIBLE
PHYSICAL THERAPY (OUTPATIENT)	90% after DEDUCTIBLE	70% after DEDUCTIBLE
PREGNANCY One mental health screening during a pregnancy for pre-partum depression and one mental health screening six months after a live birth, stillbirth, or miscarriage for postpartum depression.	Paid as any other Service	Paid as any other Service
PREVENTIVE CARE		
Routine Well Adult Care (Age 2 and older). The following are considered routine: Includes: Prostate screening Gynecological exam Pap smear Routine mammogram (dependent on age and frequency – see below) Routine physical exam X-rays Lab blood tests Routine endoscopic surgery- Colonoscopies (Age 50+) Members age 50+ shall be Allowed one (1) colonoscopy every ten (10) years with at least 10 years between each surgery date. Immunizations (age 6 & Older) Well Child exam (age 2 & Older) Tobacco Use counseling and intervention (office) fees including augmented pregnancy-tailored counseling Mental Health Screening – 1 per Calendar Year	100% DEDUCTIBLE waived	Not Covered
Routine Mammograms – age 40 + At age 40+ a woman can receive one (1) exam per CALENDAR YEAR	100% DEDUCTIBLE waived	70% after DEDUCTIBLE
Routine Vision Exam – up to age 5	100% DEDUCTIBLE waived	100% DEDUCTIBLE waived, \$25 per CALENDAR YEAR maximum

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
Routine Vision Exam – age 5 and up \$25 per CALENDAR YEAR maximum	100% DEDUCTIBLE waived	100% DEDUCTIBLE waived
Routine Well NEWBORN Care for the following: Screening for hearing loss, Screening for phenylketonuria (PKU), and Screening for sickle cell disease	100% DEDUCTIBLE waived	70% after DEDUCTIBLE
Routine Well NEWBORN Care (INPATIENT nursery charges, circumcision and related PHYSICIAN fees)	100% DEDUCTIBLE waived	70% after DEDUCTIBLE
Routine Well Child Care – To, but not through, Age 2 Includes: Office visit Routine physical examination Lab blood tests X-rays	100% DEDUCTIBLE waived	70% after DEDUCTIBLE
Routine Immunizations – to age six (6) Includes: Diphtheria Pertussis Tetanus Polio Measles Mumps Rubella Hemophilus Influenza B Hepatitis B Varicella	100% DEDUCTIBLE waived	100% DEDUCTIBLE waived
Routine Child Blood Lead Tests – to age six (6)	100% DEDUCTIBLE waived	70% after DEDUCTIBLE
Prosthetics	90% after DEDUCTIBLE	70% after DEDUCTIBLE
SKILLED NURSING FACILITY (SEMI-PRIVATE room rate) 90 days per CONFINEMENT maximum	90% after DEDUCTIBLE	70% after DEDUCTIBLE
Speech Therapy (OUTPATIENT)	90% after DEDUCTIBLE	70% after DEDUCTIBLE
URGENT CARE CLINIC* (Free-standing facility)	\$50 co-payment, then 90% after DEDUCTIBLE	\$50 co-payment, then 70% after DEDUCTIBLE
URGENT CARE ROOM* (HOSPITAL billed)	\$50 co-payment, then 90% after DEDUCTIBLE	\$50 co-payment, then 70% after DEDUCTIBLE

	NETWORK PROVIDERS % of Network NEGOTIATED FEE	NON-NETWORK PROVIDERS % of Usual & Customary
*Note: For a VALID MEDICAL EMERGENCY only. See definition of VALID MEDICAL EMERGENCY as defined in the Definition section. The co-payment will be waived if the COVERED PERSON is admitted to the HOSPITAL directly from the URGENT CARE ROOM or Clinic.		

**PRESCRIPTION DRUG BENEFIT
PLAN F789-19 (FORMERLY PLAN D)**

A prescription is required for medications listed below.

Pharmacy Option

Limited to a 30-day supply

GENERIC DRUGS, also insulin and covered birth control medications

Co-payment..... \$10.00

FORMULARY BRAND NAME DRUGS

Co-payment..... \$25.00**

NON-FORMULARY BRAND NAME DRUGS

Co-payment..... \$40.00**

Aspirin (Males age 45 to 79 and Females age 55 to 79),
Folic acid (Females only),
Iron supplements (children age 6 to 12 months),
Oral fluoride pills (children 6 months to 5 years), and
Erythromycin ophthalmic ointment (newborn 0 to 3 months)

Co-payment..... \$0

Mail Order PRESCRIPTION DRUG Option

Available for maintenance drugs. Maintenance drugs are those taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.

Limited to a 90-day supply

GENERIC DRUGS, also insulin and covered birth control medications

Co-payment..... \$20.00

FORMULARY BRAND NAME DRUGS

Co-payment..... \$50.00**

NON-FORMULARY BRAND NAME DRUGS

Co-payment..... \$80.00**

Aspirin (Males age 45 to 79 and Females age 55 to 79),
Folic acid (Females only),
Iron supplements (children age 6 to 12 months),
Oral fluoride pills (children 6 months to 5 years), and
Erythromycin ophthalmic ointment (newborn 0 to 3 months)

Co-payment..... \$0

* Exclusions and Limitations apply

** If the COVERED PERSON chooses to receive a BRAND NAME DRUG when a generic substitute is available, the COVERED PERSON will have to pay the difference between the costs of the generic substitute in addition to the brand name co-payment. However, if the COVERED PERSON'S qualified practitioner will not allow a generic substitute only the brand name co-payment will apply.

Generic Incentive Program

The PRESCRIPTION DRUG plan contains a zero-dollar CO-PAYMENT for generics program in the following therapeutic categories: The Proton Pump Inhibitor (PPI) drugs, the Angiotensin Receptor Blocker (ARB) drugs, and the HMG-CoA Reductase Inhibitor drugs ("Statins"). Members will pay \$0 for prescriptions of the following preferred generic PRESCRIPTION DRUGS at the retail and mail order pharmacy: omeprazole (PPI), pantoprazole (PPI), losartan (ARB), losartan/HCTZ (ARB), lovastatin (Statin), pravastatin (Statin), and simvastatin (Statin). Individuals taking a BRAND NAME medication in one of these drug classes should consult with, and may be asked by the CLAIMS ADMINISTRATOR and Prescription Benefit Manager to consult with, their PHYSICIAN to determine if a preferred generic alternative is appropriate. GENERIC DRUGS may be added or removed from this list by the PLAN ADMINISTRATOR at any time based on availability, price, usage patterns, or any other factor the PLAN ADMINISTRATOR determines is appropriate. Generic availability alone does not guarantee inclusion in the CO-PAYMENT waiver program. The CLAIMS ADMINISTRATOR and Prescription Benefit Manager will provide recommendations and supporting documentation to the PLAN ADMINISTRATOR relative to the GENERIC DRUGS that should be considered for the CO-PAYMENT waiver program.

*With regards to the **PRESCRIPTION DRUG BENEFIT – PLAN F789-21 (FORMERLY PLAN G)** section on pages 14-15 of this Master Plan Document, Generic Incentive Program shall be added as follows:*

Generic Incentive Program

The PRESCRIPTION DRUG plan contains a zero-dollar CO-PAYMENT for generics program in the following therapeutic categories: The Proton Pump Inhibitor (PPI) drugs, the Angiotensin Receptor Blocker (ARB) drugs, and the HMG-CoA Reductase Inhibitor drugs ("Statins"). Members will pay \$0 for prescriptions of the following preferred generic PRESCRIPTION DRUGS at the retail and mail order pharmacy: omeprazole (PPI), pantoprazole (PPI), losartan (ARB), losartan/HCTZ (ARB), lovastatin (Statin), pravastatin (Statin), and simvastatin (Statin). Individuals taking a BRAND NAME medication in one of these drug classes should consult with, and may be asked by the CLAIMS ADMINISTRATOR and Prescription Benefit Manager to consult with, their PHYSICIAN to determine if a preferred generic alternative is appropriate. GENERIC DRUGS may be added or removed from this list by the PLAN ADMINISTRATOR at any time based on availability, price, usage patterns, or any other factor the PLAN ADMINISTRATOR determines is appropriate. Generic availability alone does not guarantee inclusion in the CO-PAYMENT waiver program. The CLAIMS ADMINISTRATOR and Prescription Benefit Manager will provide recommendations and supporting documentation to the PLAN ADMINISTRATOR relative to the GENERIC DRUGS that should be considered for the CO-PAYMENT waiver program.

*With regards to the **ELIGIBILITY** section on pages 17-24 of this Master Plan Document, **Dependent Eligibility 2. Children to Age 26 under the Patient Protection and Care Act** shall be deleted in its entirety and replaced with the following:*

2. CHILDREN TO AGE 26 – An EMPLOYEE'S and/or RETIRED EMPLOYEE'S child up to age 26 is eligible for coverage through this plan regardless of marital status, employment status, or existence of other coverage. However, if the child has coverage through their own employer or through their own spouse, then this coverage will pay all benefits as secondary to that coverage as outlined in the Coordination of Benefits section in this plan document. When the child reaches limiting age, coverage will end on the child's birthday.

MILITARY SERVICE EXTENSION (WISCONSIN STATE MANDATE): A child enrolled in this plan under this eligibility section who is under age 27 and who is called to federal active military service duty in the National Guard or a reserve component of the U.S. armed forces while the child was attending, on a full time basis, an institution of higher education, and such full time service call interrupts their eligibility for coverage under this plan past the date the child reaches age 26, will be eligible for coverage under this Plan for up to twelve months of coverage if over the limiting age, upon release/return from active service duty provided the child returns to school as a full-time student within 12 months of fulfilling the active duty obligation.

*With regards to the **ELIGIBILITY** section on pages 17-24 of this Master Plan Document, **Dependent Eligibility 3. Dependent Children to Age 27 under the Wisconsin State Mandate** shall be deleted in its entirety and all following items renumbered sequentially.*

With regards to the **PRESCRIPTION DRUG EXPENSE BENEFIT** section on pages 55-58 this Master Plan Document, **Generic Incentive Program** shall be added as follows:

Generic Incentive Program

The PRESCRIPTION DRUG plan contains a zero-dollar CO-PAYMENT for generics program in the following therapeutic categories: The Proton Pump Inhibitor (PPI) drugs, the Angiotensin Receptor Blocker (ARB) drugs, and the HMG-CoA Reductase Inhibitor drugs ("Statins"). Members will pay \$0 for prescriptions of the following preferred generic PRESCRIPTION DRUGS at the retail and mail order pharmacy: omeprazole (PPI), pantoprazole (PPI), losartan (ARB), losartan/HCTZ (ARB), lovastatin (Statin), pravastatin (Statin), and simvastatin (Statin). Individuals taking a BRAND NAME medication in one of these drug classes should consult with, and may be asked by the CLAIMS ADMINISTRATOR and Prescription Benefit Manager to consult with, their PHYSICIAN to determine if a preferred generic alternative is appropriate. GENERIC DRUGS may be added or removed from this list by the PLAN ADMINISTRATOR at any time based on availability, price, usage patterns, or any other factor the PLAN ADMINISTRATOR determines is appropriate. Generic availability alone does not guarantee inclusion in the CO-PAYMENT waiver program. The CLAIMS ADMINISTRATOR and Prescription Benefit Manager will provide recommendations and supporting documentation to the PLAN ADMINISTRATOR relative to the GENERIC DRUGS that should be considered for the CO-PAYMENT waiver program.

IN WITNESS WHEREOF, **The City of Franklin** has caused this Amendment to take effect, be attached to and form a part of its Employee Health and Welfare Non-Grandfathered Plan.

Date Signed

Authorized Signature & Title

Location

Witness

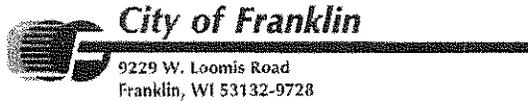


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<p>APPROVAL</p> <p><i>slw</i></p>	<p>REQUEST FOR COUNCIL ACTION</p>	<p>MEETING DATE</p> <p>9/18/2012</p>
<p>Licenses and Permits</p>	<p>Miscellaneous Permits</p>	<p>ITEM NUMBER</p> <p><i>H. 1.</i></p>

See attached list from meeting of September 18, 2012

COUNCIL ACTION REQUESTED



City of Franklin

9229 W. Loomis Road
Franklin, WI 53132-9728

414-425-7500

License Committee

Agenda*

Alderman's Room

September 18, 2012 – 6:00 pm

1.	Call to Order & Roll Call	Time		
2.	Applicant Interviews & Decisions			
	License Applications Reviewed		Recommendations	
Type/ Time	Applicant Information		Approve	Hold
Temporary Entertainment & Amusement	St Paul's Lutheran School – Fundraising Gala 6881 S 51 st St Person in Charge: Tami Pautz Date of Event: 10/6/2012			
Temporary Class B Beer & Wine	St Paul's Lutheran School – Fundraising Gala 6881 S 51 st St Person in Charge: Tami Pautz Date of Event: 10/6/2012			
New Class B Combination	Rock Sports Complex, LLC 7900 W Crystal Ridge Agent: Samantha Skeen			
Extra Ordinary Entertainment & Amusement	Rock Sports Complex – Halloween Event 7900 W Crystal Ridge Agent: Samantha Skeen Date of Event: 9/28/2012 thru 10/28/2012			
Coin Machine Operator	A-S Amusements, Inc 8655 Golden Field Dr Oak Creek, WI 53154 Owner: Agim Zejneli			
3.	Adjournment		Time	

*Notice is given that a majority of the Common Council may attend this meeting to gather information about an agenda item over which they have decision-making responsibility. This may constitute a meeting of the Common Council per State ex rel. Badke v. Greendale Village Board, even though the Common Council will not take formal action at this meeting.

APPROVAL <i>Slw CAP</i>	REQUEST FOR COUNCIL ACTION	MEETING DATE 9/18/12
Bills	Vouchers and Payroll Approval	ITEM NUMBER <i>I.1.</i>

Provided separately for Council approval is a list of vouchers Nos. 144226 through 144396 in the amount of \$ 2,455,682.44.

The net City vouchers for September 18, 2012 are \$ 2,455,682.44.

Approval is requested for the net payroll dated September 7, 2012 in the amount of \$ 349,428.58.

COUNCIL ACTION REQUESTED

Motion approving net City vouchers in the range of Nos. 144226 through 144396 dated September 18, 2012 in the amount of 2,455,682.44.

Approval is requested for the net payroll dated September 7, 2012 in the amount of \$349,428.58.