DISCLAIMER OF CLAIMS ADMINISTRATOR

We have prepared this document for your review and consideration; however, we are neither your 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 the Plan.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by City of Fond du Lac (the "Employer" or the "Plan Sponsor") as of July 1, 2023 hereby **amends and restates** the City of Fond du Lac Health and Welfare Benefit Plan (the "Plan"), which was originally adopted by the Employer, effective January 1, 2016.

Effective Date
The Plan is effective as of the date first set forth above, and each Amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts the Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date: 4/29/2024

City of Fond du Lac
By: DocuSigned by: Joe Moore 52D629508FE94CF...

Name: Joe Moore

Title: City Manager

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION CITY OF FOND DU LAC EMPLOYEE HEALTH CARE PLAN

This booklet is the Plan Document and 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 prior Summary Plan Descriptions issued to the Covered Person by City of Fond du Lac.

The Plan is funded by City of Fond du Lac and Employee contributions, if required. The benefits and principal provisions of the 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 Plan.

The purpose of providing a comprehensive medical plan is to protect the Covered Person(s) 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 Plan Sponsor 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 Plan Sponsor, 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 City of Fond du Lac.

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

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PLAN DESCRIPTION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Covered Persons and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for Covered Persons, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of the Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses. The Plan is maintained by City of Fond du Lac and may be inspected at any time during usual business hours by any Covered Person.

General Plan Information

Name of Plan:	**City of Fond du Lac Employee Health Care Plan**
Plan Sponsor:	**City of Fond du Lac** **160 S. Macy Street** **Fond du Lac, WI 54936-0150** **Phone: 920-322-3623**
Plan Administrator: **(Named Fiduciary)**	**City of Fond du Lac** **160 S. Macy Street** **Fond du Lac, WI 54936-0150** **Phone: 920-322-3623**
Plan Sponsor ID No. (EIN)	**39-6005450**
Source of Funding:	**Self-Funded**
Status:	**Non-Grandfathered**
Applicable Law:	**State of Wisconsin**
Plan Year:	**January 1st through December 31st**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**
Claims Administrator:	**Auxiant** **2450 Rimrock Road, Suite 301** **Madison, WI 53713** **Phone: 800-245-0533** **Fax: 608-270-7837** **Website: www.auxiant.com**
Participating Employer(s):	**City of Fond du Lac**
Agent for Service of Process:	**City of Fond du Lac** **160 S. Macy Street** **Fond du Lac, WI 54936-0150** **Phone: 920-322-3623**

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
The Plan Document and any Amendments constitute the terms and provisions of coverage under the Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

Mental Health Parity
Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, the Plan applies its terms uniformly and enforces parity between covered medical and surgical benefits and covered mental health and substance use disorder benefits relating to financial cost sharing restrictions and both quantitative and non-quantitative treatment limitations. For further details, please contact the Plan Administrator.

Applicable Law
This is a self-funded benefit plan coming within the purview of the laws of the State of Wisconsin. The Plan is funded with Employee and/or Employer contributions.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

Named Fiduciary and Plan Administrator
The Named Fiduciary and Plan Administrator is City of Fond du Lac, who will have the authority to control and manage the operation and administration of the Plan. 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 Maximum Allowable Charge.

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 Employee and Dependent contributions. The Employer reserves the right to increase or decrease 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 will have no further obligation to make additional contributions to the Plan as of the effective date of termination of the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the Employer may modify, amend, or discontinue the Plan without the consent of or notice to Employees. Any changes made shall be binding on each Employee and on any other Covered Persons. 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 will be used to pay benefits under the provisions of the Plan for claims arising before termination, or will be used to provide similar health benefits to Covered Employees, until all contributions are exhausted.

Claim Procedure
The Employer will provide adequate notice in writing to any Covered Employee whose claim for benefits under the Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Employee. Further, the Employer will afford a reasonable opportunity to any 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 the 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, 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, 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.

Indemnification of Employees
No director, officer, or Employee of the Employer or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act or omission done in good faith in the administration or management of the Plan, and will be indemnified and held harmless by the Employer from and against any such personal liability, including all expenses reasonably incurred in his defense if the Employer fails to provide such defense. The Employer and the Plan may individually obtain Fiduciary liability coverage consistent with applicable law.

National Correct Coding Initiative
Where not otherwise specified, the 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.

Questions or Concerns:
You may contact the Plan Sponsor, Claims Administrator, or you may also contact the United States Department of Labor at:

Employee Benefit Security Administration
Chicago Regional Office
John C. Kluczynski Federal Bldg.
230 S. Dearborn Street, Suite 2160
Chicago, Illinois 60604
Tel (312) 353-0900
Fax (312) 353-1023

BENEFIT OVERVIEW FOR CITY OF FOND DU LAC

Note: The following section is an overview of the Plan.

Eligibility Provisions

The Employee should notify the Employer of eligibility changes (i.e., Total Disability, retirement, change in Dependent status - birth, marriage, divorce, etc.) as soon as possible.

EFFECTIVE DATE OF THE PLAN	January 1, 2016 and restated on July 1, 2023.
ELIGIBLE CLASS	All Employees who work for the Employer for at least thirty (30) or more hours per week on a Regular Basis; part-time individuals who work for the Employer for at least twenty (20) hours per week. Temporary, seasonal, leased Employees and independent contractors/consultants are not eligible under the Plan. Eligible Retirees as defined in the Plan are also eligible.
WAITING PERIOD	An individual will be eligible on the first of the month following date of hire. Any Employees hired on the first of the month are effective that day.
CONTRIBUTION	The Plan may be evaluated from time to time to determine the amount of Employee contribution (if any) required.

*Please refer to the **Eligibility** section for further details.*

MANAGED CARE	The Plan requires that all non-Emergency Inpatient admissions (Hospital, Skilled Nursing Facility, Birthing Center, and other facilities) be pre-certified by the Review Organization seventy-two (72) hours prior to the admission; all Emergency Inpatient admissions must be reported within seventy-two (72) hours of admission. If an Inpatient stay is not pre-certified by the Review Organization, benefits related to the admission will be reduced by 25% of cost and/or $5,000 per Covered Transplant Procedure through the Specialty Organ Transplant Program (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

Maximum Allowable Charge	All charges are subject to the Maximum Allowable Charge for the area in which the service or supply is received, unless otherwise noted.
Hospital Room and Board Limitation	Semi-Private Rate
Intensive Care Unit Limitation	ICU Rate
Skilled Nursing Facility Room and Board Limitation	Semi-Private Rate
Maximum Benefit for Chiropractic Care	25 visits per Calendar Year; additional visits allowed if Medically Necessary
Maximum Benefit for Compression Stockings	2 pairs per Calendar Year
Maximum Benefit for Hearing Aids	$1,000 per Covered Person per every 3 Calendar Years
Maximum Benefit for Insulin Infusion Pumps	1 per Calendar Year (under medical)
Maximum Benefit for Mastectomy Bras	2 per Calendar Year
Maximum Benefit for Home Health Care	40 visits per Calendar Year
Maximum Benefit for Skilled Nursing Facility	30 days per Confinement
Maximum Benefit for Non-Surgical Temporomandibular Joint Disorder (TMJ)	6 visits per Calendar Year
Maximum Benefit for Breast Pumps	1 per Calendar Year
Maximum Benefit for Mammograms	1 per Calendar Year
Maximum Benefit for Pap Smear	1 per Calendar Year
Maximum Benefit for Prostate Screening	1 per Calendar Year
Maximum Benefit for Dialysis Therapy	$8,000 per month with the 1st month of home treatment; $8,000 per month beginning the 91st day of office/outpatient treatment
Maximum Benefit for Occupational Therapy	25 visits per Calendar Year; additional visits allowed if Medically Necessary
Maximum Benefit for Physical Therapy	25 visits per Calendar Year; additional visits allowed if Medically Necessary

Maximum Benefit for Speech Therapy	25 visits per Calendar Year; additional visits allowed if Medically Necessary

SCHEDULE OF MEDICAL BENEFITS

PPO NETWORK PLAN

The Plan utilizes a Preferred Provider Organization (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 In-Network benefit listed below. To obtain a list of the preferred providers, please reference the information provided on the ID card.

Except as stated below and within "No Surprises Act - Emergency Services and Surprise Bills", all services under the PPO Plan must be provided by participating providers to be covered at the In-Network benefit level. Services received elsewhere will be paid at the Out-of-Network level. If any of the following circumstances apply, benefits will be payable at the In-Network level based on the Maximum Allowable Charge:

- If the Covered Person has no choice of In-Network providers in the specialty that the Covered Person is seeking within the In-Network service area (includes Preventive Care).
- If Covered Services provided by a Physician during an inpatient stay will be payable at the In-Network level of benefits when provided at an Inpatient Hospital.
- When an In-Network provider utilizes the services of an Out-of-Network provider for the reading or interpretation of x-ray or laboratory tests.

If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person’s Coinsurance, Co-Payment, Deductible, and Out-of-Pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing
In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan’s position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider’s actions, including balance billing.

In addition, with respect to services rendered by an In-Network Provider being paid in accordance with a discounted rate, it is the Plan’s position that the Covered Person should not be responsible for the difference between the amount charged by the In-Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any In-Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for any applicable payment of Coinsurances, Deductibles, and Out-of-Pocket maximums and may be billed for any or all of these.

Claims Audit
In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or service that are not Medically Necessary, if any, and may include a Covered Person's medical billing records review and/or audit of the Covered Person's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in the Plan.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of the Plan.

No Surprises Act – Emergency Services and Surprise Bills
For Non-Network claims subject to the No Surprises Act ("NSA"), Covered Person cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Qualifying Payment Amount, unless the Recognized Amount applies, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, defined as items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no In-Network provider who can furnish such item or service at the In-Network facility ("Ancillary Services"). Non-Ancillary Services are also considered non-emergency services for this section, so long as the non-network provider has not given the Covered Person proper notice and/or the Covered Person has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

The benefits provided to Non-Network providers and facilities will be reimbursed based on the Out-of-Network Rate (see the Definitions section).

A note about Notice and Consent (where required): In certain situations described above, you can still be balance billed by a Non-Network provider or facility so long as provider provides to you proper notice and you (or your authorized representative's) consent to waive your rights to balance billing protections prior to the Covered Service.

If a Covered Person believes they have been wrongly billed, they may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit their question or a complaint. Covered Persons can also submit a complaint online at: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Continuity of Care
In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is

terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

The Plan shall notify the Covered Person in a timely manner that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice is provided and ending ninety (90) days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

PPO Network Plan		
	Network Providers	**Non-Network Providers**
Note: The Network and Non-Network Deductible and Out-of-Pocket maximums do not cross-satisfy one another. Any other benefit maximums cross-satisfy one another.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,000	$2,000
Per Family Unit	$2,000	$4,000
Members in a family plan are only required to satisfy the Per Covered Person Deductible before benefits will pay.		
The Deductible does not apply to: • Certain Covered Services through the Agnesian Corporate Clinic for Active Covered Employees and their covered Dependents; • Network Preventive Care; • Organ Transplants through the Specialty Organ Transplant Program; and • Pre-Admission Testing.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Includes Deductible, Coinsurance, Medical Network Co-Payments)		
The Out-of-Pocket is the maximum amount of Covered Expenses 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 Out-of-Pocket amount.		
Per Covered Person	$3,000	$6,000
Per Family Unit	$6,000	$12,000
Members in a family plan are only required to satisfy the Per Covered Person Out-of-Pocket limit.		
The Plan will pay the designated percentage of Covered Expenses until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Expenses for the rest of the Calendar Year unless stated otherwise.		

PPO Network Plan		
	Network Providers	**Non-Network Providers**
The following charges do not apply toward the Out-of-Pocket maximum: • Cost containment penalties; • Ineligible charges; • Amounts over the Maximum Allowable Charge; and • Organ Transplants through the Specialty Organ Transplant Program.		
MAXIMUM PRESCRIPTION CO-PAYMENT OUT-OF-POCKET AMOUNT*, PER CALENDAR YEAR		
Per Covered Person	$3,600	Not Applicable
Per Family Unit	$7,200	Not Applicable
***All Out-of-Pocket costs shall not exceed the federal maximum per year.**		
COVERED SERVICES FOR PROFESSIONAL FEES		
Agnesian Corporate Care Clinic Certain Services provided by a Nurse Practitioner or Physician (Deductible and Schedule of Medical Benefits may apply to additional services and tests).	100% Deductible waived	Not Covered
Allergy Injections/Serum Inpatient/Outpatient	90% after Deductible	60% after Deductible
Allergy Injections/Serum Office	90% after Deductible	60% after Deductible
Allergy Testing Inpatient/Outpatient	90% after Deductible	60% after Deductible
Allergy Testing Office	90% after Deductible	60% after Deductible
Ambulance Service	90% after Deductible	Paid at Network Level
Anesthesia Inpatient/Outpatient	90% after Deductible	60% after Deductible
Anesthesia Office	90% after Deductible	60% after Deductible
Chemotherapy/Radiation Therapy Inpatient Pre-Authorization required for prescribed treatment.	90% after Deductible	60% after Deductible
Chemotherapy/Radiation Therapy Office/Outpatient Pre-Authorization required for prescribed treatment.	90% after Deductible	60% after Deductible
Chiropractic/Spinal Manipulation Includes chiropractic lab, x-rays, supplies and evaluation and management fees. Limited to 25 visits per Calendar Year. Subject to medical necessity review after 25 visits per Calendar Year.	90% after Deductible	60% after Deductible
Compression Stockings Limited to 2 pairs per Calendar Year.	90% after Deductible	60% after Deductible
Custom Molded Foot Orthotics	90% after Deductible	60% after Deductible
Diabetic Self Education Inpatient/Outpatient	90% after Deductible	60% after Deductible
Diabetic Self Education Office	90% after Deductible	60% after Deductible

PPO Network Plan		
	Network Providers	**Non-Network Providers**
Diabetic Supplies Limited to 1 pump per Calendar Year under medical. Supplies covered under RX.	90% after Deductible	60% after Deductible
Diagnostic Lab by Independent Lab	90% after Deductible	Paid at Network Level
Diagnostic Lab/X-ray Emergency Room	90% after Deductible	Paid at Network Level
Diagnostic Lab/X-ray Inpatient and Outpatient	90% after Deductible	60% after Deductible
Diagnostic Lab/X-ray Office	90% after Deductible	60% after Deductible
Diagnostic X-ray Inpatient/Outpatient Radiologist Fees	90% after Deductible	60% after Deductible
Diagnostic X-ray Office Radiologist Fees	90% after Deductible	60% after Deductible
Durable Medical Equipment Pre-Authorization is recommended for the rental/purchase of Durable Medical Equipment (DME) over $1,000.	90% after Deductible	60% after Deductible
Hearing Aids Limited to $1,000 per Covered Person per every 3 Calendar Years.	90% after Deductible	60% after Deductible
Home Health Care Limited to 40 visits per Calendar Year. Pre-Authorization is recommended.	90% after Deductible	60% after Deductible
Hospice Care	90% after Deductible	60% after Deductible
Injections Inpatient/Outpatient/Home	90% after Deductible	60% after Deductible
Injections Office	90% after Deductible	60% after Deductible
Mastectomy Bras Limited to 2 per Calendar Year.	90% after Deductible	60% after Deductible
MRA/MRI/PET/CAT/Nuclear Cardiology Imaging/Non-Maternity Ultrasounds - Inpatient	90% after Deductible	60% after Deductible
MRA/MRI/PET/CAT/Nuclear Cardiology Imaging/Non-Maternity Ultrasounds - Office	90% after Deductible	60% after Deductible
MRA/MRI/PET/CAT/Nuclear Cardiology Imaging/Non-Maternity Ultrasounds - Outpatient	90% after Deductible	60% after Deductible
Office/Outpatient Evaluation and Management fees and Counseling fees	90% after Deductible	60% after Deductible
Orthotics	90% after Deductible	60% after Deductible
Other Covered Services	90% after Deductible	60% after Deductible
Physician Emergency Room Visits	90% after Deductible	Paid at Network Level
Physician Inpatient Visits	90% after Deductible	60% after Deductible

PPO Network Plan		
	Network Providers	**Non-Network Providers**
Physician Office Visits	90% after Deductible	60% after Deductible
Physician Outpatient Visits	90% after Deductible	60% after Deductible
Pre-Admission Testing	100% Deductible waived	60% after Deductible
Private Duty Nursing	90% after Deductible	60% after Deductible
Prosthetics	90% after Deductible	60% after Deductible
Second Surgical Opinion	90% after Deductible	60% after Deductible
Supplies Non Durable Office	90% after Deductible	60% after Deductible
Supplies Non Durable Other	90% after Deductible	60% after Deductible
Surgery below includes professional fees for anesthesia and assistant surgeon		
Surgery Inpatient	90% after Deductible	60% after Deductible
Surgery Office	90% after Deductible	60% after Deductible
Surgery Outpatient	90% after Deductible	60% after Deductible
Telemedicine	90% after Deductible	60% after Deductible
Urgent Care Clinic - Evaluation & Management fee	90% after Deductible	60% after Deductible
Urgent Care Clinic - Lab/X-ray/Supplies/Surgery	90% after Deductible	60% after Deductible
COVERED SERVICES FOR FACILITY FEES		
Birthing Center	90% after Deductible	60% after Deductible
Inpatient Miscellaneous Charges	90% after Deductible	60% after Deductible
Inpatient Rehabilitation	90% after Deductible	60% after Deductible
Inpatient Room and Board Limited to the semi-private room rate.	90% after Deductible	60% after Deductible
Intensive Care Unit Limited to the Hospital's ICU Charge.	90% after Deductible	60% after Deductible
Outpatient Clinic Fee	90% after Deductible	60% after Deductible
Outpatient Diagnostic	90% after Deductible	60% after Deductible
Outpatient Emergency Room Co-Payment waived if admitted.	$250 Co-Payment, then 90% after Deductible	Paid at Network Level
Outpatient Other Services	90% after Deductible	60% after Deductible
Outpatient Surgery	90% after Deductible	60% after Deductible
Residential Treatment	90% after Deductible	60% after Deductible
Skilled Nursing Facility Limited to 30 days per Confinement.	90% after Deductible	60% after Deductible
Transitional Treatment Facility	90% after Deductible	60% after Deductible
Teledoc Services	$0 consult fee	
Urgent Care Room Hospital Billed	90% after Deductible	60% after Deductible
COVERED SERVICES FOR BOTH PROFESSIONAL AND FACILITY FEES FOR THE FOLLOWING DIAGNOSES:		
Dental Surgery/Accident	90% after Deductible	60% after Deductible
Infertility	Paid same as any other Illness	Paid same as any other Illness
Includes: care, supplies and services for the initial diagnosis of infertility. Treatment of infertility is not covered.		

PPO Network Plan		
	Network Providers	**Non-Network Providers**
Jaw Joint/TMJ Non-Surgical treatment limited to 6 visits per Calendar Year.	90% after Deductible	60% after Deductible
Organ Transplants - not through the Specialty Organ Transplant Program Pre-Certification is required. This coverage is only available to those individuals who have been denied coverage through the specialty policy or program. A written denial from the third party specialty program or policy vendor must be obtained. Refer to the list of covered transplants in the Medical Expense Benefits section. (Co-Payments, Coinsurance, and Deductible apply to Out-of-Pocket maximums.)	Contact Auxiant	Contact Auxiant
Organ Transplants - not through the Specialty Organ Transplant Program Pre-Certification is required. This coverage is only available to those individuals who have been denied coverage through the specialty policy or program. A written denial from the third party specialty program or policy vendor must be obtained. Refer to the list of covered transplants in the Medical Expense Benefits section. (Co-Payments, Coinsurance, and Deductible apply to Out-of-Pocket maximums.)	Paid same as any other Illness	Paid same as any other Illness
Pregnancy	90% after Deductible	60% after Deductible
Preventive Care	100% Deductible waived	60% after Deductible

PPO Network Plan		
	Network Providers	**Non-Network Providers**

Preventive Care benefits include, but are not limited to, the following when the claim is submitted with a routine diagnosis:
 	
• All other lab tests;
• All other x-rays;
• Breast Pumps;
  ◦ Limited to 1 per Calendar Year;
• Contraceptives (the administration and supply for injectables, diaphragms, implants, IUD's, and office visits and laboratory work associated with contraceptives and sterilization procedures for females);
• Depression screening through Primary Care Physician office;
• Immunizations;
• Lactation counseling;
• Mammograms;
  ◦ Limited to 1 per Calendar Year;
• Pap smear;
  ◦ Limited to 1 per Calendar Year;
• Prostate screening;
  ◦ Limited to 1 per Calendar Year;
• Routine exams;
• Routine surgeries (colonoscopy);
• Routine vision exams to age 19;
• Smoking cessation – office visits/counseling;
• Well Child Blood Lead Tests to age 6; and
• Well Child Care.		

Contraceptives Contraceptive methods and counseling approved by the FDA for males.	90% after Deductible	60% after Deductible
Routine Hearing Exams	90% after Deductible	60% after Deductible
COVERED SERVICES FOR REHABILITATION THERAPY FOR BOTH PROFESSIONAL AND FACILITY FEES (Inpatient Facility fees are included in Inpatient miscellaneous Facility fees above)		
Cardiac Rehabilitation **Office/Outpatient**	90% after Deductible	60% after Deductible
Dialysis Therapy **Home/Office/Outpatient** For at home treatment (peritoneal dialysis) $8,000 maximum per month begins the first month of treatment. For office/outpatient treatment $8,000 maximum per month begins the 91st day of treatment.	90% after Deductible	60% after Deductible
Home Infusion Therapy	90% after Deductible	60% after Deductible
Occupational Therapy **Office/Outpatient** Limited to 25 visits per Calendar Year. Subject to medical necessity review after 25 visits per Calendar Year.	90% after Deductible	60% after Deductible

PPO Network Plan		
	Network Providers	**Non-Network Providers**
Physical Therapy Office/Outpatient Limited to 25 visits per Calendar Year. Subject to medical necessity review after 25 visits per Calendar Year.	90% after Deductible	60% after Deductible
Speech Therapy Office/Outpatient Limited to 25 visits per Calendar Year. Subject to medical necessity review after 25 visits per Calendar Year.	90% after Deductible	60% after Deductible

PRESCRIPTION DRUG BENEFIT

Prescription drug coverage for members is administered by the Pharmacy Benefit Manager. The Pharmacy Benefit Manager provides a nationwide network of participating pharmacies and also provides a drug formulary. The Pharmacy Benefit Manager prescription drug formulary is divided into "tiers." The presence of a drug on this formulary does not guarantee coverage. The drugs listed on the Pharmacy Benefit Manager formulary are subject to change. To find out if a medication the Covered Person is prescribed is covered under the Plan, please see the ID Card for Pharmacy Benefit Manager contact information.

MAXIMUM PRESCRIPTION CO-PAYMENT OUT-OF-POCKET AMOUNT*, PER CALENDAR YEAR	
Per Covered Person	$3,600
Per Family Unit	$7,200
***Combined with the Medical Out-of-Pocket amount and not to exceed the federal maximum per year.**	

Pharmacy Prescription Drug Benefit
Limited to a 34-day supply.

Generic Drugs		
	Co-Payment.....	$10
Formulary Brand Name Drugs		
	Co-Payment.....	$30
Non-Formulary Drugs		
	Co-Payment.....	$60

Pharmacy Prescription Drug Benefit
Limited to a 90-day supply.

Generic Drugs		
	Co-Payment.....	$30
Formulary Brand Name Drugs		
	Co-Payment.....	$90
Non-Formulary Drugs		
	Co-Payment.....	$180

Specialty Drugs
Limited to a 30-day supply.

Generic Drugs		
	Co-Payment.....	$5
Formulary Drugs Name Drugs		
	Co-Payment.....	$25
Non-Formulary Drugs		
	Co-Payment.....	$50

Mail Order Prescription Drug Benefit
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		
	Co-Payment.....	$20
Formulary Brand Name Drugs		
	Co-Payment.....	$60
Non-Formulary Drugs		
	Co-Payment.....	$120

Generic Contraceptive Prescription Drugs are a $0 Co-Payment with first dollar coverage, as required under the Patient Protection and Affordable Care Act.

Certain Prescriptions written for Preventive Care may be covered at the generic level if no generic option is available, as required under the Patient Protection and Affordable Care Act. For a complete list of covered Prescription Drugs and for information regarding drugs covered for Preventive Care, please refer to the website or booklet information provided by the Employer identified on your Drug Card.

Tobacco cessation medications (including both prescription and over-the-counter medications) for a ninety (90) day treatment regimen without prior authorization. Two (2) tobacco cessation attempts are allowed per year. Coverage does not apply to brands where an equivalent generic is available.

Specialty Drugs are not covered.

The prescription drug expense benefit may be limited or require compliance with certain restrictions such as Pre-Certification, enrollment in manufacturer rebate programs, off-label drug exclusion, and supply or pharmacy limitations. Opportunities may be available to participate in programs to lower or eliminate cost-sharing (ex: Co-Payment, Coinsurance) connected to certain prescriptions, generally specialty or otherwise high cost drugs. Contact your Drug Card service or Employer for eligibility terms and further details.

Co-Payment Accumulator Program

If the Covered Person is eligible to receive a subsidy through a manufacturer Co-Payment program, the Co-Payment will be equal to the maximum subsidy available, when applicable. Amounts credited to the Covered Person through a rebate, Co-Payment assistance, coupon, or similar manufacturer patient subsidy will not be applied to Deductible or Out-of-Pocket amounts.

ELIGIBILITY

EMPLOYEE ELIGIBILITY: Employees who belong to an **Eligible Class** of Employees are eligible for coverage under the Plan following the waiting period.

ELIGIBLE CLASS: Full-time, Active Employees who work for the Employer at least thirty (30) hours per week on a Regular Basis. Regular Basis means an Employee is regularly at work for a period of four (4) weeks in a row; such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel and for which he or she receives regular earnings from the Employer.

Part-time, Active Employees who work for the Employer at least twenty (20) hours per week on a Regular Basis. Regular Basis means an Employee is regularly at work for a period of four (4) weeks in a row; such work may occur either at the usual place of business of the Employer or at a location to which the business of the Company requires the Employee to travel and for which he or she receives regular earnings from the Employer.

Variable Hour (Non-seasonal) Employees: Any other Employees, who have qualified for coverage through a measurement period as defined by the Employer as Full-time, Active Employees for a stability period after completing a measurement period for determining Eligibility. Part-time Employees who are determined to not be considered "full-time" at the completion of a measurement period will not be eligible during the subsequent stability period. Seasonal Employees are not eligible for coverage.

A retired Employee of the Employer as defined the Employee Handbook and Collective Bargaining Agreements. If an Employee retires/semi-retires from the Employer, he/she may be eligible to continue coverage until he/she is Medicare eligible.

Temporary, seasonal, leased Employees and independent contractors/consultants are not eligible under the Plan.

WAITING PERIOD: An individual will be eligible on the first of the month following date of hire. Any Employees hired on the first of the month are effective that day.

A waiting period is the time between the first day of Full-Time Employment and the first day of coverage under the Plan.

The Plan may not base rules for eligibility for coverage upon an Employee being Actively at Work if a health factor is present. If an Employee is absent from work due to a health factor, for purposes of plan eligibility, the Employee is to be considered Actively at Work.

EMPLOYEE EFFECTIVE DATE

Employee Coverage under the Plan shall become effective on the date of the Employee’s eligibility provided he/she has made written application for such coverage on, or within thirty-one (31) days before or after, such date. Please see the Enrollment section for all requirements of Timely, Special and Late Enrollees.

DEPENDENT ELIGIBILITY

The following persons are eligible for Dependent coverage under the Plan:

1. LAWFUL SPOUSE - An Employee's or Retiree's lawful spouse, residing in the same country, if not legally separated or divorced. An Employee’s registered domestic partner will also be eligible for coverage. The Plan Administrator may require documentation proving a legal marital relationship or registered domestic partnership. A Retiree’s lawful spouse who is eligible for Medicare is not an eligible dependent. A Retiree’s spouse under the age of sixty-five (65) is not allowed to enroll in a single medical plan when the Retiree drops family coverage and

enrolls in Medicare.

Not considered eligible for spousal coverage:
a) Common law spouses.

If a divorce is pending, a spouse cannot be dropped from coverage until the divorce is finalized. A finalized divorce decree or legal separation document must be submitted in order to drop the spouse's coverage from the Plan.

2. CHILDREN TO AGE TWENTY-SIX (26) - An Employee's Child up to age twenty-six (26) is eligible for coverage through the 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 of the Plan. When the Child reaches limiting age, coverage will end on the last day of the Child's birthday month.

   MILITARY SERVICE EXTENSION (WISCONSIN STATE MANDATE):A Child enrolled in this plan under this eligibility section who is under age twenty-seven (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 twenty-six (26), will be eligible for coverage under this Plan for up to twelve (12) 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 twelve (12) months of fulfilling the active duty obligation.

3. DEVELOPMENTALLY DISABLED OR HANDICAPPED CHILDREN - An Employee's unmarried Dependent Child who is incapable of self-sustaining employment by reason of Developmental Disability or physical or mental handicap, and who is primarily dependent upon the Employee for support and maintenance is covered under the Plan when the Child reaches the limiting age. Proof of disability or handicap must be submitted to the Plan Administrator within thirty-one (31) days of the covered Dependent reaching the limiting age. Thereafter, proof may be required annually.

4. CHILDREN ENTITLED TO COVERAGE - as the result of one (1) of the following:

   a. Qualified Medical Child Support Order (QMCSO);
   b. A National Medical Support Order;
   c. Divorce Decree; and
   d. Court Order.

At any time, the Plan may require proof that a spouse or a Child qualifies or continues to qualify as a Dependent as defined by the Plan.

The term "Child" or "Children" as referenced in the above sections includes:

   a. An Employee's natural Child;
   b. An Employee's adopted Child (from the date of the placement);
   c. An Employee's stepchild;
   d. An Employee's grandchild when parent is also enrolled as a Dependent or until the Dependent Child's parent is age nineteen (19);
   e. Any other Child for whom the Employee has Legal Guardianship or for a Child for whom the Employee or spouse had noted Legal Guardianship on the Child's eighteenth (18th) birthday (proof is required).

An "adopted Child (from the date of placement)" refers to a Child whom the Employee has adopted or intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) on the date of such placement for adoption. The term placement means the assumption and retention by such 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 two (2) spouses are employed by the Employer and both are eligible for Dependent coverage, either spouse, but not both, may elect Dependent coverage for their eligible Dependents.

INELIGIBLE DEPENDENTS - Ineligible Dependents, not withstanding the foregoing section, are excluded from eligibility: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; anyone who is eligible for coverage as an Employee will not be eligible for coverage as both an Employee and as a Dependent.

DEPENDENT EFFECTIVE DATE

A Dependent will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage, subject to all limitations and requirements of the Plan. Each Employee who makes such written request for Dependent coverage on a form approved by the Employer shall, become covered for Dependent coverage as follows:

1. If the Employee makes such written request on or before the date he or she becomes eligible for Dependent coverage, or within the time frame listed to enroll in "Employee Eligibility", the Employee shall become covered, with respect to those persons who are then his or her Dependents, on the date he or she becomes covered for participant coverage.

2. If the Dependent is a Newborn Child or newly adopted Child, then the Dependent is eligible for coverage from the date of the event (i.e., birth or date of placement). The newly-acquired Dependent is automatically enrolled if family coverage is in place. If family coverage is not in place then the Plan Sponsor must be notified within thirty-one (31) days of the event. Benefits will not be paid until the Dependent is enrolled.

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 if 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 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.

EMPLOYEE ELIGIBILITY APPEALS: In cases where eligibility has been denied, an Employee may appeal the adverse eligibility determination. A letter of appeal must be submitted to the Plan Administrator no later than fifteen (15) days after the adverse determination clearly stating the following:

- Employee's full name and contact information;
- Any family members who were also denied coverage;
- The reason coverage was denied; and
- Why the eligibility determination should be reversed.

All appeal determinations from the Plan Sponsor will be final. Failure to appeal within fifteen (15) days constitutes a waiver of the right to appeal.

TIMELY ENROLLMENT

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

OPEN ENROLLMENT

During the annual open enrollment period during the months of October and November, Employees and Dependents who are Late Enrollees will be able to enroll in the Plan. Changes made during the open enrollment period shall be effective the subsequent January 1st.

During the annual open enrollment established by the Employer, an eligible Employee currently enrolled in the Plan may elect to change coverage for himself/herself and his/her eligible Dependents. An Employee will not be permitted to change any benefit election for a Plan Year after the deadline established by the Plan Administrator for the timely filing of such elections, unless the Employee experiences a Special Enrollment event.

Employees will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT

The following circumstances will constitute eligibility to enroll due to a special enrollment event.

Individuals losing other coverage (proof is required). An Employee or Dependent, who is eligible, but not enrolled in the Plan, may enroll if each of the following conditions is met:

1. The 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 the Plan was previously offered to the individual.

2. If required by the Plan Administrator, the 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 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. the Employer contributions towards the coverage were terminated.

4. The Employee or Dependent requests enrollment in the Plan no later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

5. If the loss of coverage was through a Medicaid or CHIP program, the Employee or Dependent requests enrollment in the Plan no later than sixty (60) days after the date of exhaustion or cancellation by the Medicaid or CHIP program. Coverage will begin no later than the first day of the first calendar month following the date a completed enrollment form is received.

The effective date for loss of other coverage, if eligible, is the date of the event.

If the 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. Retirees are not eligible for Special Enrollment due to loss of other coverage.

Note: If an Employee experiences a Special Enrollment Event, the Employee will be allowed to change plans (if applicable) for himself/herself and his/her eligible Dependents.

Dependent beneficiaries: A Dependent who is eligible but not currently enrolled in the Plan may enroll if each of the following conditions are met:

1. The Employee is a Covered Person under the Plan (or has met the Waiting Period applicable to becoming a Covered Person under the Plan and is eligible to be enrolled under the Plan but has failed to enroll during a previous enrollment period);

2. An individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption; or

3. The Dependent was previously covered through a Medicaid or CHIP program, and has lost eligibility for coverage through said program,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under the Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a Child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of thirty-one (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 sixty (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 marriage;

2. in the case of a Dependent's birth, as of 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.

BREAK IN SERVICE AND REINSTATEMENT OF EMPLOYEES (RETURNING TO SERVICE)

If an Employee incurs a break in service from the Employer of at least thirteen (13) consecutive weeks, they will be required to meet Eligibility requirements (including any waiting period applicable to their position) as if they were a new Employee.

Additionally, if the break in service is more than four (4) weeks, but less than thirteen (13) weeks, the Employee will be treated as a new Employee as long as the break in service period was longer than the length of their actual service period

before the break in service was Incurred.

For purposes of applying this provision, the duration of the employee's credited service with the Employer immediately preceding a period during which an Employee was not credited with Hours of Service is determined after application of any applicable rules of Special Unpaid Leave as defined in the Plan.

MANAGED CARE SERVICES

Managed Care Services are used by the Plan to reduce health care expenses and review and advise Covered Person(s) on how to best utilize the benefits of the Plan.

Any reduced reimbursement due to failure to follow Managed Care Services procedures will not apply to the Out-of-Pocket limit.

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

Managed Care Services Phone Number

Please refer to the Employee ID card for the Managed Care Services phone number.

UTILIZATION REVIEW

As part of a program designed to keep down escalating costs, the 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, procedures as defined by the utilization review administrator, for Medical Necessity of the following non-Emergency Services before Medical and/or Surgical services are provided:

    - Hospitalizations - Hospitals, 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, either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the indicated diagnosis. The Covered Person 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 forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

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

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. Covered Person(s) must contact the utilization review administrator at the telephone number on the ID card at least seventy-two (72) hours before services are scheduled to be rendered with the following information:

- Name of the Covered Person and relationship to the covered Employee;
- Name, Social Security number and address of the covered Employee;
- Name of the Employer;
- Name and telephone number of the attending Physician;
- Name of the Medical Care Facility, proposed date of admission, and proposed length of stay; and
- Diagnosis and/or type of surgery.

If there is an Emergency admission to the Medical Care Facility, the Covered Person, the Covered Person's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within seventy-two (72) hours 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 benefit payment will be reduced by 25% of cost or $5,000 per transplant procedure thought Fairmont Transplant programs.

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 and the Covered Person(s).

Benefits will be provided for a second opinion (and third, if necessary) 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 Covered Person may choose any board-certified specialist who is not associated with the attending Physician and

who is accredited in the appropriate specialty.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors the Covered Person and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the Covered Person, the family and the attending Physician in order to develop a plan of care for approval by the Covered Persons attending Physician and the Covered Person. The Plan of care may include some or all of the following:

- personal support to the Covered Person;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility services;
- determining alternative care options; and
- assistance obtaining any necessary equipment and services.

Case Management is implemented when beneficial to both the Covered Person 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, Covered Person and Covered Person'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 Covered Person and family choose not to participate.

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

TELADOC PROGRAM

Teladoc provides quality medical services via phone or online video chat for non-Emergency medical conditions. The nationwide network allows access to services anywhere twenty-four (24) hours per day/seven (7) days a week/365 days per year at 1-800-DOC-CONSULT (362-2667) or online at www.MyDrConsult.com.

Please see your Plan Sponsor for further information.

MEDICAL EXPENSE BENEFITS

Upon receipt of a claim, the Plan will pay the Benefit Percentage listed in the Schedule of Benefits for Eligible Expenses Incurred in each Benefit Period.

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 Deductible amount is shown in the Schedule of Benefits.

Family Deductible Feature

If the Family Deductible limit, as shown in the Schedule of Benefits, is Incurred by covered Family members during the Calendar Year, no further Deductibles will be required from Family members for the rest of the Calendar Year.

Maximum Allowable Charge

Subject to the Plan Administrator's exercise of discretion, the Plan shall pay no more than the Maximum Allowable Charge for covered services and/or supplies, after a reduction by all amounts payable as Coinsurance or Deductibles. All charges must be billed in accordance with generally accepted industry standards.

The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, Medicare cost to charge ratios, amounts actually collected by Providers in the area for similar services, average Provider charges, Provider costs for providing the service, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices. The intent is to allow only up to the average commercial allowable for same or similar services in the geographic area.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Out-of-Pocket Limit

Covered charges are payable at the percentage shown each Calendar Year until the Out-of-Pocket limit shown in the Schedule of Benefits is reached. Then, covered charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

Co-Payment Out-of-Pocket Limit

Co-Payments from certain covered Network services will apply toward a Co-Payment Out-of-Pocket Limit as shown in the Schedule of Benefits. Combined with the Out-of-Pocket Limit, a Covered Person's total Out-of-Pocket cost per

Calendar Year shall not exceed the federal limits set forth by Affordable Care Act and subsequent regulatory guidance. Once the Co-Payment Out-of-Pocket limit is reached, then all Co-Payments for in-Network services are covered for the rest of the Calendar Year.

Allocation and Apportionment of Benefits

The Employer 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 Treatment

In addition to the Covered Medical Expenses specified, the Claims Administrator (on behalf of and in conjunction with the Plan Administrator) may determine and pre-authorize other services to be covered hereunder which normally are excluded services or have limited coverage under the Plan. The attending Physician or Case Manager must submit an Alternative Treatment plan to the Claims Administrator 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 period of time for which such medical service(s) will be covered under the Plan. Further, the Claims Administrator will make such a determination based on each circumstance and stipulate that its approval does not obligate the Plan to provide coverage for the same or similar services for other Covered Persons nor be construed as a waiver of its rights to administer the Plan in accordance with its established provisions.

Medical Eligible Expenses

Medical Eligible Expenses include the following expenses when they are Incurred while coverage is in force for the Covered Person. If, however, any of the listed expenses are excluded from coverage in the General Limitations section, those expenses will not be considered Medical Eligible Expenses.

The Plan will pay for Medical Eligible Expenses subject to the Benefit Percentage and Maximum Amounts shown in the Schedule of Benefits.

Hospital Expenses

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

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.

Skilled Nursing/Extended Care Facility Expenses

Skilled Nursing/Extended Care Facility Expenses are payable up to the maximum in the Schedule of 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 are eligible for benefits. Covered Expenses include but may not be limited to:

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, if applicable);
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 any limits stated in the Schedule of Benefits. A Physician (either the Covered Persons 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 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:

1. Evaluation of the need for a Home Health Care Plan and development of the plan by a Registered Nurse (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 (R.N.) or medical Social Worker and are Medically Necessary for the Covered Person's care;
4. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.);
5. Physical, respiratory, inhalation, occupational and speech therapy;
6. Durable 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 dietitian.

The plan may only cover a set number of visits per person in a Calendar Year, 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:

1. Services or supplies not included in the Home Health Care Plan.
2. Services of a Close Relative.
3. Custodial Care.
4. Food, housing, homemaker services or meals delivered to the home.
5. Transportation to and from the Covered Person's home.

Hospice Care Expenses

Hospice Care for a terminally ill person provided in the Hospice Unit, an Outpatient facility or the Covered Person's home. A Physician must order the care and expect that the patient has no more than six (6) months to live. The plan may

extend Hospice Care benefits beyond six (6) months if the patient's Physician certifies that the patient is still terminally ill. Covered Hospice Care services and supplies include the following:

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.

Hospice Care benefits do not include:

1. Private or special duty nursing, except as part of a Home Health Care Plan.
2. Confinement that is 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 Covered Person or family member belongs to his or her congregation.
8. Funeral arrangements.
9. Bereavement counseling for the patient's immediate family.
10. Respite Care.

Specialty Organ Transplant Program

The Plan includes a separate specialty policy regarding human organ and tissue benefits, as explained in full in the organ transplant policy/program. All eligible Employees and their Dependents requiring human organ and tissue transplant services will have specified transplant-related charges covered under this separate policy, according to its terms and conditions.

In order to obtain 100% in-network benefits, patients must use providers in a transplant network approved by and accessed through the organ transplant program. Expenses billed by the transplant network provider that are not covered by the transplant policy are subject to the Plan's benefits and the payment terms and conditions of the transplant network provider’s contracted rates. Please contact the Plan Sponsor or Claims Administrator for further benefit information.

Organ/Tissue Transplant Expenses (not through the Specialty Organ Transplant Program)

Benefits are available to a Covered Person who is a recipient or donor of Medically Necessary covered services relating to a non-Experimental transplant. Eligible services include, but are not limited to: testing to determine transplant feasibility and donor compatibility; charges related to the transplant itself, as well as follow-up care, including: diagnostic x-ray and lab; procedures to determine rejection or success of transplant, including: 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:

1. The recipient of the organ transplant must be a Covered Person under the Plan.
2. Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not

performed.
3. There must be a reasonable expectation of survival if the Covered Person were to receive the transplant.
4. Charges Incurred by the donor are only payable if the donor has no other coverage available, i.e. group health plan, a government program, or a research program.
5. Donor expenses are covered only if the recipient is covered by the Plan.
6. Pre-approval is required.

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, except charges in relation to mechanical organs which may be necessary on a temporary short-term basis until a suitable donor organ is available will be eligible under the Plan.
3. Services or supplies furnished in connection with the transportation of a living donor.
4. Expenses associated with a non-human organ transplant.
5. Expenses associated with travel to the transplant facility.

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 determined based on the Maximum Allowable Charge.

Charges for multiple Surgical Procedures and assistant surgeons will be a Covered Expense subject to the following provision:

- The Claims Administrator follows the multiple Surgical Procedures as outlined in the Current Procedural Terminology (CPT) book, which could reduce benefit payments.

COVERED EXPENSES

1. Eligible charges performed by a designated Licensed Nurse Practitioner (L.P.N.) or Physician at **Agnesian Corporate Care Clinic** as listed in the Schedule of Benefits. Care is available for Active Covered Employees and their covered Dependents for primary care, urgent care and preventive care. Note: If a Covered Person is referred to another provider for additional services, benefits as specified by the Plan will apply.

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. The 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 an Inpatient; and/or 3) the Hospital or nursing facility where the ambulance takes the Covered Person is the nearest with adequate facilities.

4. Charges made by an **Ambulatory Surgical Center** or Minor Emergency Medical Clinic when treatment has been rendered.

5. Charges for the cost and administration of an **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. Charges for **attention deficit disorders** for diagnostic testing to determine the diagnosis, medication, and medical management of the medication, as any other Illness. All other expenses for treatment will be covered under "mental health/substance use" for mental health disorders provision.

7. Charges for **augmentation communication devices** and related instructions or therapy.

8. Treatment of **Autism Spectrum Disorders** - “Autism Spectrum Disorder” means any of the following: Autism disorder, Asperger’s syndrome and any other pervasive developmental disorder. The coverage is subject to Deductibles, Coinsurance, or Co-Payments that generally apply to other conditions under the Plan as long as the service is covered and not otherwise excluded in the limitations section of the Plan. Applied Behavior Analysis (ABA) therapy will be covered.

9. Charges for the processing and administration of **blood or blood components**, including charges for the processing and storage of autologous blood.

10. Charges related to **breast feeding** including breast pump, breast milk storage supplies, and related pump supplies, basic lactation counseling and general interventions to support and promote breast feeding are covered as a Preventive Care benefit. Lactation counseling shall be covered by any provider acting within the scope of his or her license or certification. Breast pumps will be covered up to the maximum listed in the Schedule of Medical Benefits.

11. Outpatient **cardiac rehabilitation** programs to provide supervised monitored exercise sessions following coronary bypass surgery or a heart attack within the last twelve (12) months. Limited to Phase I and II only.

12. Charges for FDA approved gene therapy and **cellular immunotherapy** when authorization of medical necessity is given prior to services being performed.

13. Visits, treatment, and consultations performed in connection with **chiropractic care** with Spinal Manipulation in a Physician's office setting. Benefits are limited to the maximum listed in the Schedule of Medical Benefits. Maintenance is not covered.

14. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV **clinical trial**, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

    1. The clinical trial is approved by any of the following:
        a. The U.S. Department of Health and Human Services.
        b. The U.S. Department of Defense.
        c. The U.S. Department of Veterans Affairs.
        d. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
    2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expenses, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

    The following items are excluded from Approved Clinical Trial coverage under the Plan:

    1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
    2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
    3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    4. A cost associated with managing an Approved Clinical Trial.
    5. The cost of a health care service that is specifically excluded by the Plan.
    6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

    If one (1) or more participating providers do participate in the Approved Clinical Trial, the qualified Covered Person must participate in the Approved Clinical Trial through a participating network provider, if the provider will accept the Covered Person into the trial.

    The Plan does not cover routine patient care services that are provided outside of the Plan’s health care provider Network unless Non-Network benefits are otherwise provided under the Plan.

15. Charges for routine **colonoscopies** shall be covered as a Preventive Care benefit, including any follow up colonoscopy after a positive non-invasive-stool based or direct visualization screening test or associated consultation completed prior to the scheduled colonoscopy as well as any subsequent polyp removal. Diagnostic colonoscopies shall be covered the same as any other Illness.

16. The administration and supply for injectable, diaphragms, implants, IUDs, and office visits and laboratory work associated with **contraceptives** and sterilization procedures for females are covered as a Preventive Care benefit.

    Charges for oral contraceptives, NuvaRing, transdermal contraceptives, and Seasonique will be covered under the Prescription Drug Expense Benefit.

17. **Cosmetic services** and supplies to repair a defect caused by an Accidental Injury or to repair a Dependent Child's congenital anomaly.

18. Charges for **cranial helmets/banding**.

19. Charges related to the testing and treatment of communication delay, motor development delays, and growth **development delays**, communication delay, perceptual disorders, sensory deficit, mental retardation and related conditions. Coverage for occupational, physical, or speech therapy for Developmental Delays due to an Accident or Illness such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy will be considered Eligible Expenses under the Plan as well as the diagnosis and treatment of attention deficit disorder.

20. 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, clinitest, glucose strips and chem. strips may be covered under the Prescription Drug program) in the treatment of diabetes. Coverage for the purchase of an insulin infusion pump is limited to the maximum listed in the Schedule of Medical Benefits. The pump must be used for thirty (30) days before purchase.

21. Charges for **dialysis** in the home, as an Inpatient or at an Outpatient dialysis center.

    For the first ninety (90) days of outpatient dialysis (see below for home dialysis), the Plan will cover dialysis treatments at the applicable Deductible and Coinsurance as listed in the Schedule of Medical Benefits. After ninety (90) days (beginning on the 91st day), the Plan will pay no more than $8,000 per month including dialysis treatments, supplies, and blood support products. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease. The Plan will pay secondary to Medicare when allowed to do so under MSP rules.

    When dialysis treatments are administered at home, or for peritoneal dialysis, the Plan will pay no more than $8,000 per month including dialysis treatments, supplies, and blood support products beginning the first month of treatment. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease.

    Dialysis: Dialysis services, equipment, supplies and medications are a covered expense under the Plan as long as they are considered Medically Necessary (subject to the coverage as identified in the Schedule of Medical Benefits) for the treatment of the Covered Person.

22. Charges for the rental, up to the purchase price, of one (1) wheelchair/scooter, Hospital bed, or other **Durable Medical Equipment** prescribed by a Physician required for Medically Necessary temporary therapeutic use or the purchase of this equipment if economically justified, whichever is less. Prior authorization is recommended for the rental/purchase of Durable Medical Equipment costing over $1,000.

    Replacement of Durable Medical Equipment will be covered if due to growth or development of a Dependent child; if Medically Necessary due to change in physical condition, or deterioration caused by normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

23. Charges for **electrocardiograms**, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

24. Charge for initial contact lenses or **eyeglasses** for aphakia, keratoconus or following cataract surgery.

25. Charges for **foot care** for the treatment of a condition resulting from weak, strained, flat, unstable or unbalanced feet when surgery is performed; treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease; diagnosis of bunions and treatment when cutting operation or arthroscopy is performed; and palliative foot care.

26. Charges for the treatment of **Gender Dysphoria** is limited to the following services:

    - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
    - Cross-sex hormone therapy:
        - Cross-sex hormone therapy administered by a medical provider (for example during an office visit).
        - Cross-sex hormone therapy dispensed from a pharmacy.
    - Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:

      Male to Female:

        - Clitoroplasty (creation of clitoris);
        - Labiaplasty (creation of labia);
        - Orchiectomy (removal of testicles);
        - Penectomy (removal of penis);
        - Urethroplasty (reconstruction of female urethra); and
        - Vaginoplasty (creation of vagina).

      Female to Male:

        - Bilateral mastectomy or breast reduction;
        - Hysterectomy (removal of uterus);
        - Metoidioplasty (creation of penis, using clitoris);
        - Penile prosthesis;
        - Phalloplasty (creation of penis);
        - Salpingo-oophorectomy (removal of fallopian tubes and ovaries);
        - Scrotoplasty (creation of scrotum);
        - Testicular prosthesis;
        - Urethroplasty (reconstruction of male urethra);
        - Vaginectomy (removal of vagina); and
        - Vulvectomy (removal of vulva).

    Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

    The Covered Person must provide documentation of the following for breast surgery:

    - A written psychological assessment from at least one (1) qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the

following criteria:

- The Covered Person has experienced persistent, well-documented Gender Dysphoria.
- The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
- The Covered Person must be eighteen (18) years of age or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two (2) qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled;
  - The Covered Person must complete at least twelve (12) months of successful, continuous, full-time, real-life experience in the desired gender.
  - The Covered Person must complete twelve (12) months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan must be based on identifiable external sources, including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

27. Charges for FDA approved **gene therapy** and cellular immunotherapy when authorization of medical necessity is given prior to services being performed.

28. Charges in connection with **hearing devices** and examinations for the prescription or fitting of hearing devices, up to the maximum listed in the Schedule of Medical Benefits. Cochlear implants will be covered according to the Wisconsin state law guidelines.

29. Charges for routine **hearing tests** or to diagnose and treat a medical condition.

30. **Home Infusion Therapy Services.** Charges for treatment or services required for the administration of intravenous drugs or solutions, which meets the following guidelines:

    a. is required as a result of a Sickness or Injury;
    b. prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility Confinement;
    c. is documented in a written plan of care;
    d. is prescribed by the attending Physician; and
    e. is pre-approved by the Plan Administrator.

    Covered Charges will include charges by a Home Health Care Agency or home infusion company for the following services:

    a. intravenous chemotherapy;
    b. intravenous antibiotic therapy;
    c. intravenous steroidal therapy;
    d. intravenous pain management;
    e. intravenous hydration therapy;
    f. intravenous antiretroviral and antifungal therapy;
    g. intravenous inotropic therapy;
    h. total parenteral nutrition;
    i. intravenous gamma globulin;
    j. intrathecal and epidural;
    k. blood and blood products;
    l. injectable antiemetics; and
    m. injectable diuretics.

    The Home Infusion Therapy Services must be:

    a. rendered in accordance with a prescribed treatment plan. The treatment plan must be: set up prior to the initiation of the Home Infusion Therapy Service; and prescribed by the attending Physician; and
    b. pre-approved by the Plan Administrator prior to the initiation of the Home Infusion Therapy Services, or in the event that services are required on a weekend, the Plan Administrator is notified the next following business day.
    c. In addition, the attending Physician must certify that Home Infusion Therapy Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility Confinement.

31. Care, treatment, services, supplies or medications in connection with treatment for **impotence.**

32. Charges for diagnostic services to determine the cause of **infertility**. Treatment of the condition causing the infertility is not covered.

33. Charges for **injectable medications** and the administration of the injections in the doctor's office, Hospital or in the patient's home.

34. Charges for **mammograms** shall be covered. Routine mammograms shall be covered according to the guidelines listed in the Schedule of Medical Benefits.

35. 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 (limited up to the maximum listed in the Schedule of Medical Benefits) and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan.

36. Charges for dressings, sutures, casts, splints, crutches, braces, custom molded foot orthotics, elastic stockings (up to the maximum listed in the Schedule of Medical Benefits) or other necessary **medical supplies**, with the exception of dental braces, orthopedic shoes, arch supports, trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription (nor will they be covered with a prescription).

37. Charges in relation to individual and group treatment of **mental health/substance use disorders.** Includes psychiatric conditions including, but not limited to, anorexia nervosa and bulimia, schizophrenia, depressive disorders (not limited to manic depression) and organic disorders (mental deficit due to a medical or physical disease).

    Benefits are available for Inpatient, Outpatient, and Transitional Treatment.

    Inpatient Treatment is care while the Covered Person is in a Hospital or an Inpatient in a state licensed residential treatment facility. Outpatient Treatment means treatment performed by a Hospital, a licensed psychiatrist (M.D.), a licensed Psychologist (Ph.D.), or a state-licensed mental health or Substance Use treatment facility or any provider acting within the scope of their license. Transitional Treatment is care while the Covered Person is partially confined in a licensed residential treatment facility.

    Collateral therapy performed with the family is a covered service.

    Note: Prescription Drugs for the treatment of Mental Health and Substance Use Disorders are covered as any other Prescription Drug for the treatment of Injury or Sickness.

38. Charges for care and treatment of **Morbid Obesity** including diagnosis, nutritional counseling by a registered dietician if the Covered Person has a >27 BMI with a co-morbidity or >30 without, and surgical treatment of Morbid Obesity including but not limited to, stomach stapling, gastric bubble, or intestinal/stomach bypass.

    The Plan does cover diet supplements if the Covered Person has a >27 BMI with a co-morbidity or >30 without.

    This Plan does not cover exercise equipment or any other items listed in the General Limitations of this SPD.

    Pre-Authorization is required for any prescribed treatment and must meet current criteria and is Medically Necessary for the completion of surgical treatment.

39. 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.

40. 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. Covered Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefits are limited to the maximum listed in the Schedule of Medical Benefits.

41. 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 mouth.
    b. Correction of congenital abnormalities of the jaw.
    c. Reduction or manipulation of fractures of facial bones.
    d. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth - such conditions require pathological examination.
    e. Incision of the accessory sinuses, mouth, salivary glands or ducts.
    f. Manipulation of dislocations of the jaw.
    g. Excision of partially or fully impacted teeth.
    h. Excision of exostosis of the jaw and hard palate.
    i. External incision and drainage of cellulitis.
    j. Removal of retained (residual) root.
    k. Frenectomy (the cutting of the tissue in the midline of the tongue).
    l. Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery and grafting) to treat gingivitis or periodontitis.
    m. Apicoectomy (the excision of the tooth root without the extraction of the entire tooth).
    n. Aleveolectomy (leveling of structures supporting teeth for the purpose of fitting dentures) but is not payable if performed in conjunction with routine extraction of natural teeth.
    o. 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. 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.

42. Charges for **Orthognathic, Prognathic and maxillofacial surgery** when Medically Necessary.

43. The exam and 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 disabling congenital condition or an Injury or Sickness. Custom molded foot orthotics are covered.

    Replacement of Orthotic Appliances will be covered if it has been more than five (5) years since the last placement of such an item, unless replacement is needed as a result of unintentional damage of the appliance, and it cannot be made serviceable by repairs. Pre-Authorization of a replacement is recommended.

44. Charges for **oxygen** and other gases, and their administration.

45. Charges for **physical therapy** by a licensed Physical Therapist or other qualified provider. Benefits are limited to the maximum listed in the Schedule of Medical Benefits.

46. Charges for **pre-admission testing** when necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

47. Eligible **Pregnancy** related expenses for an Employee or a Dependent, including Medically Necessary amniocentesis tests, are considered the same as any other medical condition under the Plan. Charges for Lamaze or other child birth classes are not covered.

48. Charges for **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 the 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.

49. Charges for **Preventive Care** services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

    Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See the following websites for more details:

    https://www.healthcare.gov/coverage/preventive-care-benefits/;
    https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
    https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
    https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
    https://www.hrsa.gov/womensguidelines/.

    NOTE: The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regardless of the sex the Covered Person was assigned at birth, his or her gender identity, or his or her recorded gender.

50. Fees for **private-duty nursing** when such services are Medically Necessary, including when:

    - provided by Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) in the Covered Person's home;
    - prescribed by a Physician for the treatment of a Sickness or Injury when the Covered Person is homebound; and
    - not more costly than alternative services that would be effective for diagnosis and treatment of the Covered Person's condition.

51. 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.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

52. Charges for **radiation therapy** or treatment, and chemotherapy. Pre-Authorization is required for any prescribed treatment.

53. Charges for **respiratory therapy** by a licensed respiratory Therapist or other qualified provider. This also includes treatment for cardiac pulmonary rehabilitation.

54. Charges for **routine Child Well-Care.** Eligible Expenses include those for office visits, developmental assessments, laboratory services, x-rays and immunizations, except mass immunizations or those required for travel.

55. Charges for **routine physicals** for individuals. Eligible Expenses include, but are not limited to, those for the office exam, any routine diagnostic services normally associated with a routine exam, and immunizations, except mass immunizations or those required for travel.

    Care and treatment of adult obesity screening/counseling is covered as a Preventive Care benefit.

    When a claim is submitted, the Physician's office must code the claim to indicate Preventive Care or the Plan will consider the claim as treatment of Sickness or Injury.

56. Charges for a voluntary **second surgical opinion** or third surgical opinion.

57. Charges for the testing, surgery or treatment for **sleep disorders.** Pre-Authorization required.

58. Charges for **smoking cessation** office visits and counseling fees will be paid as a Preventive Care benefit. Smoking cessation drugs (both prescription and over-the-counter) will be covered according to the Prescription Drug Expense Benefit.

59. Charges for **speech therapy** by a licensed Speech Therapist or other qualified provider. Benefits are limited to the maximum listed in the Schedule of Medical Benefits.

60. Charges in relation to a **sterilization** procedure. However, the reversal of a sterilization procedure is not covered. Charges in relation to female sterilizations will be covered as a Preventive Care benefit. Charges in relation to male sterilizations will be paid same as any other Illness.

61. Charges for **telemedicine** services. This includes the use of interactive audio and video telecommunication systems that allow real-time communication between the Covered Person and an Eligible Provider.

62. Charges for surgical and non-surgical treatment of **TMJ (temporomandibular joint disorder)** up to the maximum listed in the Schedule of Medical Benefits.

63. Charges made by an **Urgent Care Clinic**.

64. Charges for **x-rays, microscopic tests, and laboratory tests** along with the related radiology and pathology charges.

GENERAL LIMITATIONS

The following exclusions and limitations apply to Expenses Incurred by all Covered Persons:

1. **Abortion.**

   Charges for abortion unless Medically Necessary to safeguard the life of the mother. The Plan covers treatment of complications that arise after an abortion, whether or not the abortion was Medically Necessary.

2. **Alternative Care.**

   Charges for acupuncture, aquatic therapy, hypnotherapy, biofeedback, holistic medicine, massage therapy, Rolfing, health education, homeopathy, reiki, any type of goal oriented or behavior modification therapy, myo-functional therapy, and programs intended to provide complete personal fulfillment or harmony.

3. **Breast Feeding.**

   Supplies not related to the breast pump for breast feeding including, but not limited to, nursing pads, bottles, cleaning brushes, cooler, and power adapters are not covered under the Plan.

4. **Breast Reduction.**

   Charges for breast reduction unless Medical Necessity is established. Prior approval is recommended.

5. **Cardiac Rehabilitation.**

   Services and charges for Phase III and Phase IV cardiac rehabilitation. Also includes self-regulated physical activity that the Covered Person performs to maintain health which is not part of a treatment plan.

6. **Chelation Therapy.**

   Charges in relation to Chelation Therapy except in the treatment of heavy metal poisoning.

7. **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.

8. **Cochlear Implants.**

   Charges for cochlear implants (an implantable hearing device), except as specifically listed as covered elsewhere in the Plan.

9. **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.

10. **Copy Charges.**

    Charges for the photocopying of medical records.

11. **Cosmetic Procedures.**

    Charges in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure. 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.

12. **Court Costs.**

    Charges for court costs, penalties, interest upon judgment, investigative expenses, administrative fees or legal expenses.

13. **Criminal Activity.**

    Treatment of an Illness or Injury resulting from the commission of, or attempt to commit by the Covered Person, a felony or aggravated battery, unless the Illness or Injury results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition).

14. **Custodial Care.**

    Services or supplies provided mainly as a rest cure, maintenance or Custodial Care. Additionally, expenses Incurred for accommodations (including Room and Board and other institutional services) and nursing services for a Covered Person because of age or a mental or physical condition primarily to assist the Covered Person in daily living activities will be considered Custodial Care. The fact that the Covered Person is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying.

15. **Deductible.**

    That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Covered Person’s responsibility in accordance with the terms of the Plan.

16. **Dental Services.**

    Charges for dental services not specifically included in the Covered Expenses section described in the Plan. Hospital charges in relation to dental care, except those services which are certified by a medical doctor to be Medically Necessary to safeguard the life and health of the Covered Person due to the existence of a non-dental physical condition. Pre-Authorization is recommended.

17. **Dietary Supplements.**

    Charges for vitamins, dietary supplements and dietary formulas, nutritional supplements or low protein modified products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

18. **Durable Medical Equipment repair.**

    Charges for Durable Medical Equipment repair, maintenance or adjustments (unless covered in the Covered Expenses section of the Plan).

19. **Education and/or Training.**

    Charges for services or supplies in connection with education or training, except as specifically listed as covered elsewhere in the Plan.

20. **Excess.**

    Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

21. **Experimental and/or Investigational procedures.**

    Charges for procedures, drugs, or research studies, or for any services or supplies considered Experimental and/or Investigational are not eligible for coverage through the Plan. Please see the Definitions section of the Plan for more information.

22. **Eye Care.**

    Charges Incurred in connection with routine eye exams, routine eye refractions, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices.

23. **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 has concealed any material fact, the Plan will be entitled to terminate coverage and not make benefit payments.

24. **Foot Care.**

    Charges for routine foot care, such as removal of corns, calluses, or trimming of toenails; except the services necessary in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy.

25. **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 the Maximum Allowable Charge in the area of residence of the Covered Person in the United States. Fees and charges exceeding the Maximum Allowable Charge shall be disallowed as ineligible charges. Charges equal to or less than the Maximum Allowable Charge shall be considered. In no event shall benefit payment exceed the actual amount charged.

26. **Genetic Testing/Counseling.**

    Charges related to genetic testing and genetic counseling, unless Medically Necessary. However, charges for genetic counseling and evaluation related to breast cancer susceptibility will be covered according to Preventive Care requirements.

27. **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.

28. **Grandchild.**

    Charges for a grandchild of an Employee or covered spouse unless the grandchild satisfies the definition of eligible Dependent Child under the Plan.

29. **Growth Hormones.**

    Charges for medications, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency.

30. **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, except as specifically listed as covered elsewhere in the Plan.

31. **Hearing Therapy.**

    Charges for hearing therapy.

32. **Home Birth.**

    Charges for scheduled childbirth at home.

33. **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.

34. **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.

35. **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. This exclusion does not apply if the Injury resulted (a) from being the victim of an act of domestic violence, or resulted (b) from a medical condition (including both physical and mental health conditions).

36. **Implants.**

    Charges related to maxillary or mandibular implants.

37. **Incarcerated.**

    Charges for services or supplies received while incarcerated in a penal institution or in legal custody.

38. **Infertility.**

    Charges for the 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 not covered by the Plan, donor semen or egg, and sperm banking.

39. **Inpatient Concurrent Services.**

    Charges for Inpatient concurrent services of Physicians, unless there is a clinical necessity for supplemental skills and two (2) or more Physicians attend the Covered Person for separate conditions during the same Hospital admission.

40. **Learning Disabilities.**

    Charges or non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

41. **Maintenance Therapies.**

    Charges for maintenance therapies.

42. **Marital and/or Family Counseling.**

Charges for services or supplies for marital and/or family counseling or training services. However, collateral therapy is covered.

43. **Medicare.**

The Plan complies with the requirements of the Medicare Secondary Payer (MSP) Rules as issued and periodically amended or changed. In situations where an individual is eligible for Medicare, the Plan will pay as dictated by the MSP requirements, regardless of whether the Covered Person has actually enrolled in any part of Medicare. If Medicare would be primary under these rules for a Medicare-eligible participant, then the Plan will pay as if it were secondary, even if there was no Medicare enrollment. If the Plan would be primary under MSP rules over Medicare, then the Plan will pay as Primary regardless of Medicare entitlement.

44. **Mental Health Exclusions.**

Benefits provided for any of the following:

a. Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided;
b. Bereavement counseling, unless specifically listed as covered benefit elsewhere;
c. Services provided for conflict between the Covered Person and society which is solely related to criminal activity;
d. Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases – Clinical Modification manual (most recent version) (ICD-CM) in the following categories:
    i. Personality disorders;
    ii. Sexual disorders;
    iii. Behavior and impulse control disorders; or
    iv. Learning disorders;
    v. Senility disorders;
    vi. Paraphilias;
    vii. Gambling disorders; or
    viii. "Z" codes (including marriage counseling).
e. Services for biofeedback.

45. **Motor Vehicles.**

Charges related to the rental or purchase of a motor vehicle, or charges associated with the conversion of a motor vehicle to accommodate a disability.

46. **Negligence.**

Charges for an Injury resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

47. **No Charge.**

Expenses for which a charge would not ordinarily be made in the absence of this coverage.

48. **No Obligation to Pay.**

    Charges for which the Covered Person is not (in the absence of this coverage) legally obligated to pay.

49. **Nocturnal Enuresis Alarm.**

    Charges for treatment of nocturnal enuresis alarm (bed wetting).

50. **Non-Emergency Hospital Admission.**

    Care and treatment billed by a Hospital for a non-Emergency admission on a Friday or a Saturday. This provision does not apply if the surgery is performed within twenty-four (24) hours of admission.

51. **Non-Prescription Medications.**

    Non-prescription medicines, vitamins, nutrients, and nutritional supplements, even if prescribed or administered by a Physician.

52. **Not Medically Necessary.**

    Care and treatment that is not Medically Necessary.

53. **Not Recommended by a Physician.**

    Charges 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.

54. **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 the Plan.

55. **Nutritional Consultation.**

    Nutritional consultation or instruction, service or supplies for educational, vocational or training purposes, except as specifically listed as covered elsewhere in the Plan, except as covered according to Preventive Care requirements.

56. **Obesity.**

    Care and treatment of non-morbid obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment Plan for another Sickness. Medically Necessary charges for surgical treatment of Morbid Obesity will be covered. Charges for obesity screening/counseling shall be covered as a Preventive Care benefit.

57. **Occupational.**

    Expenses for Injuries or Sicknesses arising out of, or in the course of, any occupation or employment for wage or profit, or 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.

58. **Orthopedic Shoes.**

    Charges for orthopedic shoes, arch supports, or any such similar device, or for the prescription or fitting thereof.

59. **Penile Prosthesis.**

    Charges for penile prosthesis/implants and any charges relating thereto.

60. **Personal Comfort.**

    Modifications to your home or property as well as charges for services or supplies which constitute beautification items; for television or telephone use; for nutritional supplements; or in connection with Custodial Care, education or training, or expenses actually incurred by other persons. Charges for the purchase or rental of items including but not limited to air conditioners, humidifiers, dehumidifiers, air purifiers, allergy-free pillows, blankets or mattress covers, electric heating units, saunas, swimming pools, orthopedic mattresses, vibratory equipment, elevators, stair lifts, exercise equipment, blood pressure instruments, stethoscopes, clinical thermometers, tanning equipment, ramps, scales, elastic bandages or stockings, non-Hospital adjustable bed, non-Prescription Drugs and medicines, first aid supplies and other such equipment.

61. **Personal Injury Insurance.**

    That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Covered Person actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Covered Person's election of lesser coverage. This exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

62. **Plan Design Exclusions.**

    Charges excluded by Plan design as mentioned in this document.

63. **Provider Error.**

    Charges that are required as a result of an unreasonable provider error.

64. **Radial Keratotomy.**

    Charges in relation to radial keratotomy, Lasik, corneal modulation, refractive keratoplasty or any similar procedure.

65. **Radioactive Contamination.**

Charges Incurred as a result of the hazardous properties of nuclear material.

66. **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.

67. **Routine Medical Examinations.**

Charges Incurred for routine medical examinations or care, routine health checkups, or immunizations that are completed for insurance or licensing purposes, except as specifically listed as covered elsewhere in the Plan.

68. **Scar Removal.**

Charges related to surgical treatment of scarring secondary to acne or chicken pox to include, but not be limited to dermabrasion, chemical peel, salabrasion, and collagen injections, unless causing pain.

69. **Self-inflicted Injury.**

Charges in relation to intentionally self-inflicted Injury or self-induced Sickness. This exclusion does not apply if the Injury resulted (a) from being the victim of an act of domestic violence, or resulted (b) from a medical condition (including both physical and mental health conditions).

70. **Services Before or After Coverage.**

Charges Incurred prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless an Extension of Benefits provision applies.

71. **Sonograms.**

Charges for non-medical prenatal sonograms for such reasons as purpose of fetal age and size determination if there are no indicated complications.

72. **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).

73. **Surgical Sterilization Reversal.**

Charges related to or in connection with the reversal of a sterilization procedure.

74. **Taxes.**

Charges for sales tax, shipping and handling unless covered elsewhere in this plan.

75. **Telephone Consultations.**

    Charges for failing to keep an appointment, telephone consultations, internet and e-mail consultations, the completion of a claim form, an itemized bill or providing necessary medical records or information in order to process a claim, unless specifically listed as covered elsewhere in the Plan. This exclusion includes interprofessional telephone/internet consultations in which a provider requests the opinion and/or treatment advice of a consultant to assist in the diagnosis and/or management of the patient's care.

76. **Third Party Examination.**

    Non-medical evaluations for employment, marriage license, judicial or administrative proceedings, school, travel or purchase of insurance, etc. This exclusion does not apply to sports physicals performed at the Agnesian Corporate Care Clinic.

77. **Third Party Recovery, Subrogation and Reimbursement.**

    Charges, or any portion thereof, for an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

78. **Travel Expenses.**

    Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Expense.

79. **Unreasonable.**

    Charges that are unreasonable in nature or in charge (see definition of Maximum Amount or Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

80. **Vision Therapy.**

    Charges for vision therapy and all related services.

81. **Vocational Rehabilitation.**

    Charges for vocational rehabilitation and service for educational or vocational testing or training.

82. **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.

Notwithstanding any other provision of the Plan, the Plan shall apply coverage for Emergency Services without regard to any other term or condition of the coverage, other than: for the exclusion of coordination of benefits; applicable waiting period; applicable cost sharing.

PRESCRIPTION DRUG EXPENSE BENEFIT

Your Medical Identification (ID) card includes a section for your prescription benefits. It will show your Pharmacy Benefit Manager logo and contact number, pharmacy ID number, and pharmacy group number. Eligibility and benefit information is available online.

A directory of participating pharmacies is available on the Drug Card's web site. A print version is also available upon your request. The pharmacy directory is a separate document from the Plan. The directory contains the name, address and phone number of the pharmacies that are part of the Drug Card.

Covered Drugs

Your Drug Card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating "Caution: Federal law prohibits dispensing without a prescription." Your pharmacist or the prescribing Physician can verify coverage for a drug by contacting the Drug Card service at the number on your ID card. A complete list of covered and excluded drugs is available on the Drug Card's web site. If you are unable to access the Drug Card's web site, your Employer will provide a copy upon request at no charge.

How to Use the Prescription Drug Card

Present the ID card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the applicable Co-Payment, Deductible or Coinsurance amount as shown in the Schedule of Benefits.

If you are without your ID card or at a non-participating pharmacy, you may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from your Employer.

Mail Order Drug Service

If you are using an ongoing Prescription Drug, you may purchase that drug on a mail order basis. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a Regular Basis.

The applicable Co-Payment, Deductible or Coinsurance amount for mail order prescriptions are shown in the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card's web site or from your Employer. All prescriptions will be mailed directly to your home.

TERMINATION OF COVERAGE

Employee Termination

Employee Coverage will automatically terminate upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The end of the month the Employee terminates employment.
2. The end of the month the Employee ceases to be in a class of individuals eligible for coverage.
3. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
4. The date the Plan is terminated; or with respect to any individual benefit of the Plan, the date of termination of such benefit.
5. The date the Employee enters active duty military service.
6. The date of the Employee's death.
7. The date the Employee knowingly misrepresents/falsifies information to the Plan.

Dependent Termination

Dependent coverage will automatically terminate upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The date the Dependent ceases to be an eligible Dependent as defined in the Plan.
2. The end of the month the Dependent Child reaches the limiting age of twenty-six (26).
3. The end of the month of termination of the Employee's coverage under the Plan.
4. The date the Employee ceases to be in a class of individuals eligible for Dependent coverage.
5. The date for which the last contribution is made if the Employee fails to make any required contributions when due.
6. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit.
7. The date the Dependent enters active duty military service.
8. The date the Dependent becomes covered under the Plan as an Employee.
9. When the Employee's death occurs, Dependent(s) may continue coverage with the required premium (unless Employee’s death was due to the line of duty, then all premium payments are paid by the Employer). Coverage will continue, until:

a. The date the Dependent spouse remarries;
b. The date coverage would have termination for any other reason other than death; or
c. The date the Dependent Child coverage would have terminated had you not died.

10. In the event of a divorce, the spouse will be terminated the date the divorce decree is finalized.

RESCISSION OF COVERAGE

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

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

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by the Covered Person or the Covered Person's personal representative.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a thirty (30) day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under the Plan.

EXTENSION OF BENEFITS

Paid Leave

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

Leave of Absence/Long Term Disability

In the event of an Employer-approved leave of absence or long term disability leave, benefits for the Employee and covered Dependents will continue from the date the Employee would otherwise have terminated coverage for period as specified in the Employee Handbook and Bargained Labor Contracts. Any costs associated with this continued coverage are the responsibility of the party paying such costs prior to the reduction of working hours.

To be eligible for this provision, the Employer must approve the leave of absence. A leave of absence may be taken as the result of an Injury or Sickness, family leave, Hospital Confinement, or for personal reasons.

This continued coverage would also apply if the Employee returned to work for less than the regularly scheduled hours per week if working hours are restricted by the attending Physician.

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

This provision runs concurrently with the Family and Medical Leave Act (FMLA) when applicable.

Family and Medical Leave Act of 1993 (FMLA) Provision

Subject to the Plan’s applicability with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, the Plan shall comply with FMLA leave when applicable regardless of the established leave policies mentioned elsewhere in the Plan.

During any leave taken under the FMLA, the Employer will maintain coverage under the 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 Employee and his or her covered Dependents if the 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 the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Employee eligibility requirements, the obligations of the Employer and 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 Covered Person with questions concerning any rights and/or obligations should contact the Plan Administrator or his/her Employer.

The FMLA Act generally provides for twelve (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 Military Duty** -- Employees who have a spouse, parent, or Child who is

on or has been called to active military duty in the Armed Forces may take up to twelve (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 military duty in the Armed Forces may take up to twenty-six (26) weeks of leave to care for the injured service member in a twelve (12) month period (in combination with regular FMLA leave).

Military Leave

If an Employee is called to mandatory active duty or military training in any branch of the United States military, 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. An Employee on voluntary duty or voluntarily remaining on active duty beyond the initial call of duty will not be eligible to remain on the Plan. The Employee must request the Military Leave of absence. Military Leave is granted an addition to all other leave of absences.

General Employee who is on Military Leave whose leave ends must request in writing to have the continuation of benefits extended.

For further details on qualifying for Military Leave please refer to the Employer’s Human Resources or Employee handbook and/or Bargained Labor Contracts.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Introduction

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

Coverage

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- twenty-four (24) months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA Notice and Election

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances. Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

Payment

If the military leave orders are for a period of thirty (30) days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of thirty-one (31) days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered

Dependents will be required to pay up to 102% of the full premium for the coverage elected.

Extended Coverage Runs Concurrent

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

COBRA Extension of Benefits

Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under City of Fond du Lac Plan Document (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons 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 is City of Fond du Lac, 160 S. Macy Street, Fond du Lac, WI 54936-0150, 920-322-3623. Certain aspects of COBRA continuation coverage for the Plan is administered by Auxiant. Complete instructions on COBRA, as well as election forms and other information, will be provided by Auxiant to Covered Persons who become Qualified Beneficiaries under COBRA.

COBRA Continuation Coverage In General: COBRA continuation coverage is the temporary extension of plan coverage that must be offered to certain Covered Persons 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 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, the spouse of a covered Employee, or a Dependent Child of a covered 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 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" includes not only common-law 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 is attributable to a period in which the individual was a non-resident 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 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.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

3. The divorce or legal separation of a covered Employee from the Employee's spouse.

4. A covered 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, or the covered spouse or a Dependent Child of the covered 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 twelve (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, or the spouse, or a Dependent Child of the covered 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 an 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 family members will be entitled to COBRA continuation coverage even if they failed to pay the 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 sixty (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 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 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 sixty (60) days or less and only during the six (6) 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 thirty (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 Employee,

3. commencement of a proceeding in bankruptcy with respect to the Employer, or

4. enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (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 sixty (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 in accordance with the procedures below.

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
City of Fond du Lac
160 S. Macy Street

Fond du Lac, WI 54936-0150

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 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). If the Employee or their spouse or Dependent Children do not elect continuation coverage within the sixty (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 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 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) twenty-nine (29) months after the date of the Qualifying Event, or (ii) the first day of the month that is more than thirty (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 eighteen (18) months after the Qualifying Event if there is not a disability extension and twenty-nine (29) months after the Qualifying Event if there is a disability extension.

2. In the case of a covered 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 ends on the later of:

    a. Thirty-six (36) months after the date the covered Employee becomes enrolled in the Medicare program; or

    b. Eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered 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 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 thirty-six (36) months after the Qualifying Event.

Circumstances when the maximum coverage period will be expanded: If a Qualifying Event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second Qualifying Event that gives rise to a thirty-six (36) month maximum coverage period, the original period is expanded to thirty-six (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 thirty-six (36) months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within sixty (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 sixty (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 sixty (60) days after the date of the determination and before the end of the original eighteen (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: 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 thirty (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 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 forty-five (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 thirty (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

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of the Plan.

Excess Insurance
If at the time of Injury, Illness, or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

a. Any primary payer besides the Plan.
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
c. Any policy of insurance from any insurance company or guarantor of a third party.
d. Worker's compensation or other liability insurance company.
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. The Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the General Limitation section in the Plan up the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person’s election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses
"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, reasonable, eligible item of expense, at least a portion of which is covered under the Plan. When some Other Plan pays first in accordance with the section entitled Application to Benefit Determinations herein, the Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Claim Determination Period
"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits:

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, the Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of

the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the Primary Plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent;
3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

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

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from

liability.

Right of Recovery

In accordance with the section entitled Recovery of Payments, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan 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 guarantor(s) of a third party (collectively "Coverage").

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 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. 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. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

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). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. 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. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under the 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, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

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. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement,

execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, 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.

If the Covered Person(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. 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 all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or 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 and extends until the date upon which the liable party is released from liability. 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. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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, express written consent of the Plan.

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.

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).

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 Illness, Injury, or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Illness, 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 the 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 any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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.

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, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. 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.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or

that will be Incurred, prior to the date of the release of liability from the relevant entity, 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).

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.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under the Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

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.

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.

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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

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; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences. This incident must be a sufficient departure from the claimant's normal and ordinary lifestyle or routine. The condition must be an instantaneous one, rather than one which continues, progresses or develops.

ACTIVELY AT WORK
An Employee is considered to be Actively at Work when performing, in the customary manner, all of the regular duties of their occupation with the Employer. An Employee shall be deemed Actively at Work on each day of a regular paid vacation; on a regular non-working day, provided they were Actively at Work on the last preceding regular working day; or as otherwise noted in the Eligibility section.

ADVERSE BENEFIT DETERMINATION
Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual’s eligibility to participate in a plan or coverage;
2. A determination that a claimed benefit is not a covered benefit;
3. A rescission of coverage;
4. The imposition of a source of injury limitation, or other limitation on otherwise covered benefits;
5. A determination that a claimed benefit is Experimental, Investigational, or not reasonable, Medically Necessary or appropriate; or
6. Invalid Charges.

ALLOWABLE EXPENSES
The Maximum Allowable Charge for any Medically Necessary eligible item of expense, at least a portion of which is covered under the Plan and Incurred while the Covered Person is eligible for benefits under the Plan.

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 Covered Person 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, duly signed by the authorized person or persons as designated by the Plan Administrator.

APPROVED CLINICAL TRIAL
A phase I, II, III or IV trial that is federally funded by specified agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Patient Protection and Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless Out-of-Network benefits are otherwise provided under the Plan.

ASSIGNMENT OF BENEFITS
An arrangement whereby the Covered Person assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of the Plan. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

BENEFIT PERCENTAGE
That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket expenses in excess of the annual Deductible which are to be paid by the Employee.

BENEFIT PERIOD
A time period of one (1) Calendar Year. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one (1) 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 Covered Persons who develop complications or require pre- or post- delivery Confinement.

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

CERTIFIED IDR ENTITY
An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

CHELATION THERAPY
The technique of introducing a substance into the circulatory system to remove minerals from the body. Often used to treat poisoning by heavy metals like iron, lead and arsenic. Used Experimentally to attempt to reduce arterial plaque.

CHILD
An eligible Dependent Child, as defined in the Eligibility section of the Plan.

CHIP
The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section as may be amended from time to time.

CHIPRA
The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to as such act.

CHIROPRACTOR CARE
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 the Plan.

CLAIMS ADMINISTRATOR
The person or firm under contract with the Employer to provide consulting services to the Employer in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

CLEAN CLAIM
A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

CLOSE RELATIVE
The spouse, parent, brother, sister, Child, or in-law of the Covered Person.

CO-PAYMENT
An amount of money that is paid by the Covered Person each time a particular service is used.

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

COINSURANCE
That figure shown as a percentage in the Schedule of Medical Benefits used to compute the amount of benefit payable when the Plan states that a percentage is payable.

CONFINEMENT
A continuous stay in the Hospital(s) or Skilled Nursing Facility(ies) or combination thereof, due to a Sickness or Injury diagnosed by a Physician.

CONVALESCENT PERIOD
A period of time commencing with the date of Confinement by a Covered Person in a Skilled Nursing 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.

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 EXPENSES
Services and supplies which are not specifically excluded from coverage under the Plan and are Medically Necessary to treat Injury or Sickness.

COVERED PERSON
Any Employee or Dependent of an Employee meeting the eligibility requirements for coverage as specified in the 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: 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 during a Benefit Period before any other covered expenses can be considered for payment according to the applicable Benefit Percentage.

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. For the purpose of this definition, a Physician will be considered to be a Dentist when he or she performs any of the dental services described herein and is operating within the scope of his license.

DEPENDENT
A person meeting the eligibility requirements under the Plan for benefit coverage payable as a consequence of Eligible Expenses Incurred for a Sickness or Injury.

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 the 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:

- Ambulatory Surgical Center
- Audiologist (MS)
- Birthing Center
- Certified Counselor
- Certified Registered Nurse
- Anesthetist
- Chiropractor
- Clinic
- Dentist
- Dialysis Center
- Home Health Agency
- Hospice
- Hospital
- Laboratory
- Licensed Practical Nurse
- Medical Supply Purveyor
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath
- Outpatient Psychiatric Treatment Facility
- Outpatient Substance Use 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
- Speech Therapist

"Eligible Provider" shall not include the Covered Person or any Close Relative of the Covered Person.

EMERGENCY
A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

EMERGENCY MEDICAL CONDITION
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES
Emergency Services means, with respect to an Emergency Medical Condition:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Covered Person is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as:

- The attending emergency physician or treating Provider determines that the Covered Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the Covered Person's medical condition. The attending emergency physician's or treating Provider's determination is binding on the facility for purposes of this requirement.
- The Provider or facility furnishing such additional items and services satisfies the notice and consent criteria prescribed by federal law with respect to such items and services.
- The Covered Person is in a condition to receive the notice and consent, as determined by the attending emergency physician or treating Provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable State law.
- The Provider or facility satisfies any additional requirements or prohibitions as may be imposed under State law.

A nonparticipating provider or nonparticipating facility described above will always be considered Emergency Room Services with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfied the notice and consent requirement described above.

EMPLOYEE
An active Employee of the Employer receiving compensation from the Employer for services rendered to the Employer. Employee means a person who is in an Employer-Employee relationship with the Employer and who is classified by the Employer as a regular Employee. The term Employee does not include any Employee covered by a collective bargaining agreement that 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 Employer. The term Employee does not include an Employee classified by the Employer as a temporary Employee.

EMPLOYEE COVERAGE
Coverage hereunder providing benefits payable as a consequence of an Injury or Sickness of an Employee.

EMPLOYER
City of Fond du Lac

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.

ESSENTIAL HEALTH BENEFITS
Essential Health Benefits mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. This is a self-funded plan which is not required to cover Essential Health Benefits; however, some items and services may be covered at the discretion of the Plan Sponsor.

EXPENSES INCURRED
The day expenses or services are rendered.

EXPERIMENTAL
Services, supplies, care and treatment 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.

Experimental or investigational services typically include:

1. Care, procedures, treatment protocol or technology which is:

    a. 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
    b. 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.

2. Drugs, tests, and technology which are:

    a. Not FDA-approved for general use;
    b. Considered Experimental; or

c. For investigational use.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. 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 Plan Administrator will be guided by the following principles in review; if

1. 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. 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. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of any on-going phase of clinical trial, 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. 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. The Plan Administrator may also rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, The National Comprehensive Cancer Network (NCCN), Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining investigational or Experimental services.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named drug is not specifically excluded under the General Limitations of the Plan; and
2. The named drug has been approved by the FDA; and
3. The Off-Label Drug Use is appropriate and is the standard accepted by the medical community for the condition being treated; and
4. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer.

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.

FAMILY UNIT
A Covered Employee and their eligible Dependents.

FIDUCIARY
City of Fond du Lac, which has the authority to control and manage the operation and administration of the Plan.

FORMULARY
A list of prescription medications and drugs specifically covered by the Plan which are safe, effective and therapeutic.

FULL-TIME EMPLOYMENT
A basis whereby an Employee works for the Employer for an average of at least thirty (30) hours per week on a Regular Basis. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel and for which he receives regular earnings from the Employer.

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.

GINA
The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of Genetic Information.

HIPAA
The Health Insurance Portability and Accountability Act of 1996, as amended.

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 (1) Physician and at least one (1) 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. 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 Skilled Nursing Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE CARE
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. Hospice care must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse, and its staff must maintain central clinical records on all patients. Hospice care must meet the standards of the National Hospice Organization (NHO) and applicable state licensing.

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 Covered Person's expense.

2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located 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. Such treatment is provided 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 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 for the treatment of psychiatric problems, Substance Use, 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.

HOUR OF SERVICE
Means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR §2530.200b-2(a)). The term "Hour of Service" does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code §§861 through 863 and the regulations thereunder. An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or Affiliated Group. Hours of Service for all Employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due.

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 (1) 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 (1) Sickness.

INCURRED
A Covered Expense is Incurred on the date a service is rendered or a supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT
A health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

INJURY
The term "Injury" shall mean only accidental bodily Injury caused by an external force, occurring while the Plan is in effect. All injuries to one (1) person from one (1) accident shall be considered an "Injury."

INPATIENT CARE
Hospital Room and Board and general nursing care for a person confined in a Hospital or Skilled Nursing Facility as a bed patient.

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

INVALID CHARGES
This means (a) charges that are found to be based on “Errors,” not applicable to the service or treatment provided, through “Unbundling,” or; (b) charges for fees or services determined to not have been Medically Necessary, or exceed the Maximum Allowable Charge; or (c) charges that are otherwise determined by the Plan Administrator to be not valid or impermissible based on any applicable law, regulation, rules, or professional standard.

JAW JOINT DISORDERS
Includes conditions of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

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.

LEAVE OF ABSENCE
A period of time during which the Employee must be away from their primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by their Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

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

LEGAL SEPARATION AND/OR LEGALLY SEPARATED
An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

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.

LIFETIME
The term "Lifetime," which is used in connection with benefit maximums and limitations, means the period during which the person is covered under the Plan, whether or not coverage is continuous. Under no circumstances does "Lifetime" mean during the Lifetime of the Covered Person.

MAXIMUM ALLOWABLE CHARGE
The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be an amount based on the Out-of-Network Rate.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, Medicare cost to charge ratios, amounts actually collected by Providers in the area for similar services, average Provider charges, Provider costs for providing the service, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices. The intent is to allow only up to the average commercial allowable for same or similar services in the geographic area.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

MEDICAL CARE FACILITY
A Hospital, or a facility that treats one or more specific types of Sickness or Injury or any type of Skilled Nursing Facility.

MEDICAL EMERGENCY
A sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

MEDICAL RECORD REVIEW
The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

MEDICALLY NECESSARY/DENTALLY NECESSARY
The service a Covered Person receives which is recommended by a Physician and is required to treat the symptoms of a certain Injury or Sickness. Although the service may be prescribed by a Physician, it does not mean the service is Medically Necessary. 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 Covered Person's condition which is unlikely to ever occur if the treatment is not administered.

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

MENTAL DISORDERS
A condition which is classified as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder of any kind. To be considered a Mental Disorder under the Plan the condition must be defined as such in the "International Classification of Disease Adopted" under 10 Section F - Mental Disorders.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)
"Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")" means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage). Also, there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

MINOR EMERGENCY MEDICAL CLINIC
A free-standing facility 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. For the purposes of the Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

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.

MORBID OBESITY
A diagnosed condition in which the body weight exceeds the medically recommended weight for the person of the same height, age and mobility as the Covered Person, per the guidelines set forth in the insurance industry.

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 Covered Persons.

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 Covered Person 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.

ORTHOTIC APPLIANCE
An external device used to support, align, prevent, or correct the function of movable parts of the human body.

OTHER PLAN
Other Plan shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

OUT-OF-NETWORK RATE
With regard to services that are subject to balance billing protections, the Out of Network Rate is the amount used to calculate the benefit payable to the Out of Network Provider for Covered Expenses. The Out of Network Rate will equal (i) the Recognized Charge, (ii) an amount agreed to by the Plan and the provider, (iii) or the amount determined payable in accordance with the independent dispute resolution process.

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 facility, or an Outpatient Substance Use 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 Covered Persons.

OUTPATIENT SUBSTANCE USE TREATMENT FACILITY
An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or Substance Use; provides detoxification services needed with its effective treatment program; provides infirmary-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 Covered Person supervised by a Physician, based on the Covered Person's medical, psychological, and social needs and meets licensing standards.

OUTPATIENT SURGERY
Outpatient Surgery includes, but is not limited to, the following types of procedures performed in a Hospital or surgical 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 angiocardiography.

PART-TIME EMPLOYMENT
A basis whereby an Employee works for the Employer for an average of at least twenty (20) hours per week on a Regular Basis. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel and for which he receives regular earnings from the Employer.

PARTICIPATING HEALTH CARE FACILITY
A Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

PATIENT PROTECTION AND AFFORDABLE CARE ACT
The Patient Protection and Affordable Care Act (ACA) of 2010, as amended.

PEDIATRIC SERVICES
Services provided to individuals under the age of nineteen (19).

PHYSICAL THERAPY
A licensed practitioner who treats Covered Persons 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 the Plan. A Physician shall not include the Covered Person or any Close Relative of the Covered Person.

PLAN ADMINISTRATOR
The Employer which is responsible for the management of the Plan who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator (or similar decision-making body) has the sole authority and discretion to interpret and construe the terms of the Plan and to 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, including any alleged vague or ambiguous term or provision, and to determine payment of benefits or claims under the Plan and any and all other matters arising under the Plan.

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. The Plan Administrator has the final and discretionary authority to determine the Maximum Allowable Charge.

PLAN YEAR
The twelve (12) month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year. The Plan recognizes Plan Year as January 1st to December 31st.

PRE-AUTHORIZATION
Pre-Authorization is the formal, written determination of benefits applicable to an expense as of the date of the review by the Claims Administrator. A Pre-Authorization for benefits assumes that all information necessary to make an appropriate benefit determination has been provided. A Pre-Authorization is a guarantee that the Plan provides benefits for a covered expense as long as: 1) The Covered Person is still a Covered Person on the date of service; 2) The applicable plan benefit has not been changed; 3) The Pre-Authorization request is received in writing by the Claims Administrator via mail, electronically or by facsimile; 4) Any applicable plan maximum has not been exceeded.

PRE-CERTIFICATION
Pre-Certification is the formal request for determination of the medical appropriateness of the level of and length of care in an inpatient admission and certain ambulatory and Outpatient procedures, as defined by the Plan, for an Injury or Illness. Pre-Certification is a plan requirement of notification for potentially large medical expenses. The only purpose of Pre-Certification is to determine whether the Covered Person is receiving services in the least restrictive setting, according to the general standards of medical and surgical care.

Pre-Certification assures that the Covered Person is receiving the most appropriate level of treatment for their medical condition. Pre-Certification does not guarantee that benefits will be available when services are performed because several plan provisions may apply to the services received by the Covered Person. Pre-Certification is not a guarantee that a service/supply is covered under the Plan, and Covered Persons need to review the General Limitations and the Covered Expenses sections of the Plan, regardless of Pre-Certification.

PREGNANCY
That physical state which results in Childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

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 a prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drugs 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.

Participating pharmacies are charged to communicate any updates or changes to the Plan pharmacy program which impact a Covered Person. Covered Persons will receive notices regarding any Plan modifications regarding drugs or therapies at the time they present a prescription for drugs or drug therapies impacted by modifications to the Plan.

PREVENTIVE CARE
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 the Plan will consider the claim as treatment of an Injury or Sickness.

PRIMARY PLAN
Under an applicable Coordination of Benefits clause, a plan whose allowable benefits are not reduced by those of another plan.

PRIOR TO EFFECTIVE DATE OR AFTER TERMINATION DATE
Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility under the Plan, as well as charges Incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

PRONOUNS
Any references to "Covered Person", "He", "She", "Himself" or "Herself" means the eligible Employee and Covered Dependents.

PSYCHIATRIC CARE
The term "Psychiatric Care," also known as psychoanalytic care, means treatment for 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.

PSYCHOLOGIST
A registered clinical Psychologist. A Psychologist who specializes in the evaluation and treatment of mental Sickness who is registered with the appropriate state registering body or, in a state where statutory licensure exists, holds a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, meets the following qualifications: Has a doctoral degree from an accredited university, college, or professional school and has two (2) years of supervised experience in health services of which at least one (1) year is post-doctoral and one (1) year in an organized health services program; or, holds a graduate degree from an accredited university or college and has not less than six (6) years as a Psychologist with at least two (2) years of supervised experience in health services.

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 Plan Sponsor as a source of coverage.

A National Medical Support notice, issued pursuant to applicable regulations, will also meet the definition of a QMCSO.

Should any Covered Person or beneficiary need a copy of the procedures that govern Qualified Medical Child Support Order (QMCSO) determinations, they will be provided by the Plan Administrator, free of charge, upon request.

QUALIFYING PAYMENT AMOUNT
The methodology for determining the Qualifying Payment Amount is set by federal regulations at 29 CFR 2590.716-6, and is adjusted from time to time. “Qualifying Payment Amount” generally means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan’s Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

RECOGNIZED AMOUNT
“Recognized Amount” is defined by federal regulations at 29 CFR 2590.2590.716-3. Generally, Recognized Amount means, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider’s billed charge or the Qualifying Payment Amount.

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 an Employee is regularly at work as shown in the section titled Eligibility for Coverage. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel and for which he or she receives regular earnings from the Employer.

RETIREE
A retired Employee of the Employer as defined the Employee Handbook and Collective Bargaining Agreements. If an Employee retires/semi-retires from the Employer, he/she may be eligible to continue coverage until he/she is Medicare eligible.

REVIEW ORGANIZATION
The organization contracting with the Employer to perform managed care services.

ROOM AND BOARD
All charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing 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 Skilled Nursing Facility in which at least two (2) patient beds are available per room.

SICKNESS
A person's Illness, disease or Pregnancy (including complications).

SIGNIFICANT BREAK IN COVERAGE
A period of sixty-three (63) or more consecutive days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits.

With respect to a Qualified Covered Person who elects COBRA Continuation Coverage pursuant to the American Recovery and Reinvestment Act of 2009 and the Department of Defense Appropriations Act, 2010, the following periods shall be disregarded for purposes of determining the sixty-three (63) day break in coverage period:

1. The period beginning on the date of the Qualifying Event; and
2. The period ending with the start of COBRA Continuation Coverage.

SKILLED NURSING FACILITY
An institution, or distinct part thereof, operated pursuant to law, and one 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.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist Covered Persons 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 Covered Persons and under the full-time supervision of a Physician or Registered Nurse.
3. It provides twenty-four (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 Covered Person.
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 disability, custodial or educational care, or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term shall apply to Expenses Incurred in an institution referring to itself as a Skilled Nursing Facility, or any such other similar facility.

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 Use.

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.

SPECIAL UNPAID LEAVE
Means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

SPECIALTY DRUGS
Certain pharmaceuticals and/or biotech or biological drugs that are high-cost/high technology and are used in the management of chronic or genetic disease, including, but not limited to, injectable, infused or oral medications, or that otherwise require special handling, dispensing conditions or monitoring, delivered by any means including by purchase at a pharmacy and processed for payment by the Pharmacy Benefit Manager (PBM) or an Outpatient basis from a provider or facility or purchased directly by the Covered Person. A Specialty Prescription Drug is categorized and listed as such by the contracting PBM as it determines such list from time to time.

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.

SPINAL MANIPULATION
Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in the vertebral column.

SUBSTANCE USE
Any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

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.

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. Care and treatment may include, but are not limited to, orthodontics, crowns, inlays, Physical Therapy and any appliance that is attached to or rests on the teeth.

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 a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
4. Physical Therapy - the treatment by physical means, electrotherapy, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part.
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. An 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
In a Transitional Treatment program, services are rendered in a less restrictive manner than inpatient services but in a more intensive manner than are Outpatient services and can represent the following:

1. A non-residential program which provides case management, counseling, medical care and psychotherapy on a Regular Basis for a scheduled part of a day and a scheduled number of days per week. 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 twenty-four (24) hours, but more than four (4) hours, a day.
2. A residential treatment program in a qualified facility certified by the Department of Health and Family Services and is designed to provide individualized, active treatment within an intensively staffed residential setting. Residential Treatment Facilities are less restrictive and less intensively staffed than Hospital-based programs, but more intensively staffed and provide a wider range of services than community residences.

URGENT CARE CLINIC
A free-standing facility 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 facility must include x-ray and laboratory equipment and a life support system. These types of facilities bill on HCFA or CMS 1500 forms with Place of Service 20.

URGENT CARE ROOM
Hospital billed room that is used for treating conditions of lesser severity then would be needed with an Emergency Room. Hospitals bill Urgent Care Rooms with Revenue Code 456 or 516 on a Hospital bill (UB-92 or UB-04 for example).

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.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under the Plan.

Health Claims
All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Covered Person has not Incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Covered Person has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Covered Person receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Covered Person then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, types of claims include: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on going course of treatment to be provided over a period of time or number of treatments, and either:

    a. The Plan determines that the course of treatment should be reduced or terminated; or
    b. The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

    If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service health claims must be filed with the Claims Administrator within eighteen (18) months of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within forty-five (45) days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-Service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-Service Urgent Care Claims:
    - If the Covered Person has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.
    - If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim.
    - The Covered Person will be notified of a determination of benefits as soon as possible, but not later than

seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:

- The Plan's receipt of the specified information; or
- The end of the period afforded the Covered Person to provide the information.

- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method. Alternatively, the Covered Person may request an expedited review under the external review process.

- Pre-Service Non-Urgent Care Claims:

  - If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

  - If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment, before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan Amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the Covered Person makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

  - Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-urgent claim or a Post-

Service Claim).

- Request by Covered Person Involving Rescission. With respect to rescissions, the following timetable applies:

Notification to Covered Person	thirty (30) days
Notification of Adverse Benefit Determination on appeal	thirty (30) days

- Post-Service Claims:
  - If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
  - If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

- Extensions - Pre-Service Urgent Care Claims. No extensions are available in connection with Pre-Service Urgent Care Claims.

- Extensions - Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions - Post-Service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following:

- Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Covered Person's right to bring a civil action following an Adverse Benefit Determination on final review;
- A statement that the Covered Person 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 Covered Person's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request;
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and
- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Covered Persons at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Covered Persons the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named Fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

5. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

8. That a Covered Person will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Covered Person's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and

9. That a Covered Person will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Covered Person to respond to such new evidence or rationale.

Requirements for Appeal

The Covered Person must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For pre-service urgent care claims, if the Covered Person choose to orally appeal, or to file an appeal in writing (a written appeal must be addressed and mailed or faxed), the Covered Person may contact:

Auxiant
2450 Rimrock Road, Suite 301
Madison, WI 53713
Phone: 800-245-0533
Fax: 608-270-7837
Website: www.auxiant.com

Or

City of Fond du Lac
160 S. Macy Street
Fond du Lac, WI
54936-0150
Phone: 920-322-3623

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Covered Person;
- The Employee/Covered Person's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, the expenses may be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the appeal.
- Pre-service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim - pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Covered Person with notification of a Plan's Adverse Benefit Determination on review with respect to a.) pre-service urgent care claims, by telephone, facsimile or similar method; and b.) all other types of claims, in writing or electronically, setting forth:

- Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Covered Person's right to bring a civil action following an Adverse Benefit Determination on final review;
- A statement that the Covered Person 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 Covered Person's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy will be provided to the Covered Person, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided, or if this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what options may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final
If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision by the Plan Administrator (or other appropriately named Fiduciary of the Plan) on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. **Scope**

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. **Standard external review**

Standard external review is external review that is not considered expedited (as described in paragraph C of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

d. The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. **Expedited external review**

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   b. A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph B.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit

Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph B.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Covered Person to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under the Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to the Plan of the qualification of a guardian for his or her estate, the Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

Assignments
Benefits for medical expenses covered under the Plan may be assigned by a Covered Person to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its Fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with the Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers
Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such the Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, the Plan may recover the amount of the over-payment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) was paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from any other payer determined to be primary to the Plan and/or the Employee or Dependent on whose behalf such payment was made.

An Employee, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When an Employee or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Employee and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of the Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments

made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur interest of 1.5% per month. If the Plan must bring an action against an Employee, Provider or other person or entity to enforce the provisions of this section, then that Employee, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Employees and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Employees) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Employees are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under the Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under the Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if an Employee fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under the Plan in any such instance.

The deduction may be made against any claim for benefits under the Plan by an Employee or by any of his Covered Dependents if such payment is made with respect to the Employee or any person covered or asserting coverage as a Dependent of the Employee.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Employee for any outstanding amount(s).

Medicaid Coverage

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

GENERAL PROVISIONS

Applicable Law
This is a self-funded benefit plan coming within the purview of the laws of the State of Wisconsin. The Plan is funded with Employee and/or Employer contributions.

Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of any applicable law, as it applies to Employee welfare plans.

Fraud
The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of

funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Administrator.

Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the section entitled Recovery of Payments, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents.

Statements
All statements made by the Plan Sponsor or by a Plan Participant 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 Plan Participant.

Any Plan Participant 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 Plan Participant 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.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take Reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Covered Person's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for Amendment and incorporate any Amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by

the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    b. In the event any of the individuals described in above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose Reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, will cooperate with the Plan to correct violation or non-compliance and impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor to obtain proposals or adjustments for modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has dis-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and
    d. a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other

required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a Reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Covered Person would like to be contacted. The Plan will accommodate all Reasonable requests.

3. Copy of this Notice: The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

6. Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

City of Fond du Lac

160 S. Macy Street
Fond du Lac, WI 54936-0150
Phone: 920-322-3623

Additional Contact Information for HIPAA Questions:

City of Fond du Lac
160 S. Macy Street
Fond du Lac, WI 54936-0150
Phone: 920-322-3623

Additional Contact Information for Questions:

Employee Benefit Security Administration
Chicago Regional Office
John C. Kluczynski Federal Bldg.
230 S. Dearborn Street, Suite 2160
Chicago, Illinois 60604
Tel (312) 353-0900
Fax (312) 353-1023

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions;

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for plan administration Functions (as defined in 45 CFR 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate reporting or reporting procedures to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, concurrent with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

TO: ALL COVERED PERSON(S)
SUBJECT: WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify you, as a Covered Person or beneficiary of the Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a Covered Person or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending Physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Items 1. and 2. above will be payable under the Inpatient surgery benefit, and item 3. will be payable under the prosthetic benefit. For further details on Deductible and Coinsurance for these benefits, please refer to the Schedule of Benefits and Covered Expenses sections of the Plan.

Please call Auxiant at (800) 279-6772 for more information.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your Children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a state that provides premium assistance, contact your State Medicaid or CHIP office to find out if premium assistance is available. States with premium assistance and contact information are listed on the EBSA website: https://dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. EBSA can also provide more information about premium assistance programs and special enrollment rights. EBSA contact information is as follows:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must allow you to enroll in your Employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within sixty (60) days of being determined eligible for premium assistance.

If you or your Dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or go to www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an Employer-sponsored plan.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information
Individuals may now buy policies through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your Employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins each year from November 1st through December 15th.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your Employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your Employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your Employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your Employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your Employer that would cover you (and not any other members of your family) is more than the Affordable Care Act's affordability percentage for the year, (9.61%, as indexed, of your household income for the year), or if the coverage your Employer provides does not meet the “minimum value” standard set by the Patient Protection and Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your Employer, then you may lose the Employer contribution (if any) to the Employer-offered coverage. Also, this Employer contribution—as well as your Employee contribution to Employer offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.