PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

CITY OF JANESVILLE BENEFIT PLAN CHOICE 330 PLAN

Restated: January 1, 2017

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INTRODUCTION

This document is a description of the City of Janesville Benefit Plan ("Plan"). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Members, qualifying Domestic Partners, spouses, and qualifying Dependents against certain health expenses as specified under this Plan.

Coverage under the Plan will take effect for an eligible Employee and designated spouse, qualifying Domestic Partners, and qualifying Dependents when the Employee and each such qualifying spouse, Domestic Partner, and Dependent(s) satisfy the Probationary period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, and/or amend the Plan at any time, for any reason, and without prior or other notice.

Amendments and changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the Plan to accept all types of providers as a Participating Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this Plan coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Members are limited to Covered Charges incurred before termination, amendment, or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date, and Termination. Explains eligibility for coverage under the Plan, funding of the Plan, and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Quality and Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Member is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover (*subrogate*) payment of charges when a Member has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation of coverage options which are available.

SCHEDULE OF BENEFITS

Verification of Eligibility # - (888) 577-7724

Please call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits and services described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; and that services, supplies, and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services and benefits, not excluded by the Plan, must be prior authorized or reimbursement from the Plan may be reduced.

If admission is on an Emergency basis, Quality and Care Management must be notified within two (2) business days following the admission.

The attending Physician does not have to obtain prior authorization 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.

If you have questions about services that require prior authorization, please contact customer service (number on your ID card). Additional information can be obtained about your medical Plan at deancare.com/ASO/members/aso-medical-management/.

A prior authorization can only be obtained for services that are covered under your plan benefits. For example, if bariatric surgery is an exclusion of your policy, a prior authorization will not change that exclusion. If the services and benefits are covered under your Plan, they are also still subject to any applicable cost sharing (i.e. copays, co-insurance or deductibles).

Type of Service Requiring Prior Written Authorization (see Quality and Care Management Services Section for additional information)
All **Hospital Admissions** (IP and Observation).
Ambulance transport (Non-emergent)
AODA/Behavior/Mental Health services (Inpatient & Partial Day)
Bariatric Programs and Surgical Services for the diagnosis of Morbid Obesity
Clinical trials
Durable Medical Equipment (DME) >$500; Oxygen does not need a prior authorization
Elective outpatient **Radiology Procedures**: as outlined on deancare.com/ASO/members/aso-medical-management/
Enteral feedings
Genetic Testing
Hearing Aids limited benefit, see Medical Benefit for further details on what is covered.
Home Health Care

Home Infusion
Hospice Services
Medical Injectables
New technologies not commonly accepted as standard of care
Outpatient **hyperbaric chamber**
Some Outpatient surgery procedures per DHP Medical Policies
Pain management outpatient services (including Epidural Steroid Injections)
Physical Therapy (>8 visits)
Potentially **cosmetic procedures**
Prophylactic Mastectomy
Pulmonary Rehabilitation (>24 visits)
Occupational Therapy (>8 visits)
Skilled Nursing Facilities (SNF)
Speech Therapy (after initial visit)
Transplant Services

Please see the Quality and Care Management section in this booklet for details.

The Plan is one which contains multiple Preferred Provider Organizations (PPO). The Alliance is the primary network used for the Choice option. All other network options are based upon where the Employee lives.

PPO name:	**Alliance**
Address:	P.O. Box 44365 Madison, WI 53744-4365
Telephone:	(800) 223-4139
Website:	the-alliance.org
PPO name:	**Health EOS/Multiplan**
Address:	P.O. Box 6090 DePere, WI 54115-6090
Telephone:	(800) 279-9776
Website:	healtheos.com
PPO name:	**PHCS** Dean Health Plan
Address:	P.O. Box 99906 Grapevine, TX 76099-9706
Telephone:	(800) 922-4362
Website:	multiplan.com
PPO name:	**First Health** Dean Health Plan
Address:	P.O. Box 99906 Grapevine, TX 76099-9706
Telephone:	(800) 266-5116
Website:	myfirsthealth.com

All Out-of-Network Covered Charges under the Plan are payable at the Plan's Usual and Reasonable limits. All In-Network providers contracted amounts are used to determine reimbursement and not Usual and Reasonable limits. The deductible and coinsurance limits apply to all Covered Charges, unless stated otherwise below. Copays are not applied to the out-of-pocket limit.

To receive the highest level of benefits, the Member and Dependents should seek services from an In-Network provider. In-Network provider's are determined as follows:

In-Network Provider

Primary Network Options (availability based on where the Member resides):

- The Alliance Network
- HealthEOS+
- First Health Network
- PHCS Network

The primary network selected during "open enrollment" is considered the "In-Network provider", and Multiplan providers are considered "out-of-network". An Employee Member is only able to select a different network option at open enrollment or if the employee moves out of their primary network service area during the plan year. If a Member moves out of the service area, they shall notify the Janesville Human Resources Office of the desire to change networks. The network change will be effective on the 1st of the month following the date of the notification. Any other changes in eligibility or benefit choices need to follow standard plan criteria.

Under the following circumstances, In-Network benefits shall apply for MultiPlan and any other Out-of-Network providers.

- If a Member has no choice of In-Network Providers in the specialty that the Member is seeking within the PPO network, prior authorization would need to be obtained in order for coverage to be paid at the In-Network benefit level.
- Services received from a physician, pathologist, anesthesiologist, radiologist or emergency room physicians are always considered In-Network when an In-Network facility is utilized. If a Member is out of the PPO network and has urgent or emergent services including emergency ambulance services are also considered In-Network and the health services shall be subject to the Usual & Customary guidelines.

Out-of-Network Provider

Excluding the exception described above, MultiPlan Providers and any provider not contracted with the Member's primary network will be considered Out-of-Network Providers, and benefits shall be payable as described in the Medical Benefits Schedule.

For any provider not contracted with the Member's primary network, reimbursement shall be subject to Usual and Reasonable fees, unless listed as an exception in the Summary Plan Document. Under the following circumstances, the higher In-Network payment shall be made for certain Out-of-Network services:

You require Medical Emergency care.

If you receive treatment from an Out-of-Network provider that would be a Covered Charge from an In-Network provider, and as a result of that Out-of-Network treatment, a Covered Charge is incurred from an Out-of-Network provider that is a pathologist, anesthesiologist, or radiologist, that is covered at the higher In-Network amount.

Note: In all instances when an Exclusive or Participating Provider Network is in place with the Plan, and that network's contract with its Exclusive or Participating Providers precludes the use of Usual and Reasonable guidelines, and services are provided by a Plan/Network Provider, then claims considerations will be based on the contracted network allowances. Usual and Reasonable guidelines will be pre-empted in these instances.

Usual and Reasonable Charges for Out-of-Network Claims

From time to time, Members on the Health Plan seek treatment either in an emergency situation, or under the Choice Plan Network, and they find later that an ancillary provider s/he uses is not part of their primary network. In this case, the Member shall be billed and shall pay for any Usual and Reasonable balance that the Health Plan doesn't pay, but many times, the Member would have no idea that the ancillary provider is not part of the network. The following procedure is in place to alleviate the Member responsibility in those situations.

When these situations occur, the Plan will automatically attempt to negotiate a reimbursement agreement with the out-of-network (ancillary) provider.

- If there is a successful negotiation (anything up to ninety percent (90%) of billed charges), then the claims shall be paid at that amount with no balance due by the Member.

If the negotiation is unsuccessful, then the claims shall be handled on a case-by-case basis, during a Member's appeal. The appeal process is outlined on your Explanation of Benefits, or for further information, please contact Dean Customer Service at (888) 577-7724.

Deductibles, Coinsurance, and Copayments Payable by Plan Members

Deductibles, if applicable, are dollar amounts that the Member must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Member. Typically, there is one deductible amount per person per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required and must be paid by the Member. Maximum deductibles may be set by the Plan annually and per family unit.

Coinsurance, if applicable, is an amount of money that the Plan Member is responsible to pay after the Calendar Year deductible has been satisfied by the Member and before the out of pocket maximum has been reached.

Copayments, if applicable, are dollar amounts per service and item that the Member shall pay before the Plan pays.

A copayment is the amount of money that is paid each time a particular service is used or qualifying health item is purchased. Typically, there may be copayments on some services and other services might not have any copayments.

UTILIZATION REVIEW PLAN

Quality and Care Management will handle prior authorization requirements of your Plan. You, the Member are responsible for making sure that a prior authorization is obtained. For Medical Emergencies outside of your primary network, you must call within the time frames shown below. The Quality and Care Management toll-free number is shown on the back of your ID card.

UTILIZATION REVIEW PLAN	NON-COMPLIANCE PENEALTY	ADDITIONAL INFORMATION
Pre-Admission Prior Authorization	20% to a maximum of $500 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan, if applicable. The penalty is not applied to the out-of-pocket limit.	To prior authorize your services you must call Quality and Care Management at least seven (7) days in advance of any non-Emergency inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean delivery, must be certified by Quality and Care Management. If your admission is not certified, benefits will be payable after the non-compliance penalty. If admission is on an Emergency basis, Quality and Care Management must be notified within two (2) business days following your admission.
Prior Authorization of Outpatient Procedures	20% to a maximum of $500 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan, if applicable, and is not applied to the deductible, coinsurance or out-of-pocket maximums.	You must call Quality and Care Management at least seven (7) days in advance of any non-Emergency outpatient surgeries, diagnostic procedures or services listed in the text. If your surgery or diagnostic procedure is not certified, benefits will be payable after the non-compliance penalty. If surgery is on an Emergency basis, Quality and Care Management must be notified within two (2) business days following your surgery or diagnostic procedure.
Outpatient Behavioral Health Prior Authorization	20% to a maximum of $500 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the Plan, if applicable, and is not applied to the deductible, coinsurance or out-of-pocket maximums.	The Member must contact Customer Service at (888) 577-7724 prior to your first visit for any outpatient behavioral health treatment. If your visits are not pre or post certified, benefits will be payable after the non-compliance penalty.

MEDICAL BENEFITS SCHEDULE

CHOICE 330 PLAN			
Lifetime Maximum Benefit Amount	Unlimited		
Annual Maximum Benefit Amount	Unlimited		
Note: The **Maximim Out-of-Pockets** listed below are the total for both In-Network and Out-of-Network expenses and are separate. All other maximums listed in the **Medical Benefits Schedule** for visit limitations or specific benefit maximums, are a maximum for both In-Network and Out-of-Network combined.			
DEDUCTIBLE, PER CALENDAR YEAR – *The In-Network & Out of Network Deductible are separate.*			
	IN-NETWORK PROVIDERS (see page 4-5)	**MultiPlan & Out-Of-Network Providers**	
Per Member	$ 400	$ 800	
Per Family Unit	$ 800	$ 1,600	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - *The In-Network & Out of Network Deductible are separate, see Pharmacy Benefit Schedule for a separate Pharmacy Maximum Out-of-Pocket.*			
Per Member	$ 1,500	$ 3,000	
Per Family Unit	$ 3,000	$ 6,000	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. • Prior Authorization penalties • Amounts over Usual and Customary Charges • Prescription Copayments and/or Coinsurance			
Note: Limitations and Exclusions apply to all Covered Charges. A service that may be considered Medically Necessary may be considered excluded or supplied with an excluded item. Please see the MEDICAL BENEFITS and the PLAN EXCLUSIONS sections for additional details.			
COVERED CHARGES – Plan pays:			
	IN-NETWORK PROVIDERS (see page 4-5)	**MultiPlan & Out-Of-Network Providers**	**ADDITIONAL INFORMATION**
A. Diagnostic Services			
Diagnostic Testing *(x-ray & lab)*	80% after deductible	60% after deductible	Dental x-rays limited to covered oral surgery or injury.
Imaging Services CT/MRI/MRA	80% after deductible	60% after deductible	
PET Scans	80% after deductible	60% after deductible	
Independent Lab	80% after deductible	60% after deductible	
Sleep Study	80% after deductible	60% after deductible	
B. Hospital and Surgical Services			
Chemotherapy	80% after deductible	60% after deductible	
Dialysis	80% after deductible	60% after deductible	
Inpatient Rehabilitation	80% after deductible	60% after deductible	
Intensive Care Unit	80% after deductible	60% after deductible	
Outpatient Surgery	80% after deductible	60% after deductible	

CHOICE 330 PLAN			
Room and Board	80% after deductible	60% after deductible	Payable at the semiprivate room rate
Skilled Nursing Facility	80% after deductible	60% after deductible	Skilled Nursing Care must be in lieu of an acute care setting. Excludes Custodial Care and other non- covered expenses Limited to 120 days per Calendar Year
C. Emergency Services			
Ambulance Service	80% after deductible	80% after In-Network deductible	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.
Emergency Room	$ 150 copay per visit	$ 150 copay per visit	The copay is waived if admitted to the Hospital directly from the Emergency Room.
Emergency Room Ancillary Services	80% after deductible	80% after In-Network deductible	Emergency room treatment is limited to Medical Emergencies, as defined by the Plan.
Urgent Care/ Walk-In Clinic	80% after deductible	80% after In-Network deductible	
Urgent Care/ Walk-In Clinic Ancillary Services	80% after deductible	80% after In-Network deductible	
D. Physician Services			
Surgery	80% after deductible	60% after deductible	
Anesthesia	80% after deductible	60% after deductible	
Emergency Room Visit	80% after deductible	60% after deductible	
Inpatient/Outpatient visits	80% after deductible	60% after deductible	
Diagnotic Test Interpretations	80% after deductible	60% after deductible	
Office visits - PCP	80% after deductible	60% after deductible	
Specialist office visits	80% after deductible	60% after deductible	
Chiropractic office visits	80% after deductible	60% after deductible	
E. Other Covered Charges			
Allergy testing, serum & injections	80% after deductible	60% after deductible	
Cochlear Implants	80% after deductible	60% after deductible	Cochlear Implant coverage is for Children under 18 & Replacement Parts for Children or Adults
Diabetic Educational Training	80% after deductible	60% after deductible	Diabetic supplies and insulin are payable under the Prescrition Drug Card.
Durable Medical Equipment	80% after deductible	60% after deductible	

CHOICE 330 PLAN			
Hearing Aids	80% after deductible	60% after deductible	Not Covered for Adults. Children under 18 Limited to one aid per ear every 36 months with no dollar maximum.
Hearing Services	80% after deductible	60% after deductible	Routine Hearing Exams fall under the Preventive Benefit. Not Covered for Adults.
Home Health Care	80% after deductible	60% after deductible	Home Health Care must be in lieu of a covered Confinement in a Hospital. Limited to 40 visits per Calendar Year.
Hospice Care	80% after deductible	60% after deductible	Hospice Care must be in lieu of a covered Confinement in a Hospital or Skilled Nursing Home.
Infertility Benefits	Not Covered	Not Covered	
Jaw Joint/TMJ/TMD	80% after deductible	60% after deductible	
Initial Repair of Accidental Injury to Natural Teeth	80% after deductible	60% after deductible	
Oral Surgery Consult	80% after deductible	60% after deductible	
Oral Surgical Services	80% after deductible	60% after deductible	
Orthotics	80% after deductible	60% after deductible	
Pregnancy	80% after deductible	60% after deductible	See the Preventive Section for some Maternity services covered under Well Women's at 100% for In-Network Services.
Prosthetics	80% after deductible	60% after deductible	
Spinal Manipulation Chiropractic	80% after deductible	60% after deductible	Routine or Maintenance care is not covered.
F. Transplants & Kidney Disease Services			
Kidney Disease Treatment	80% after deductible	60% after deductible	
Transplant Services	80% after deductible	60% after deductible	
G. Psychological Disorders, Chemical Dependence, Alcoholism Benefit			
Detoxification Services	80% after deductible	60% after deductible	
Inpatient Facility	80% after deductible	60% after deductible	
Outpatient Facility	80% after deductible	60% after deductible	
Office visits	80% after deductible	60% after deductible	
Partial Day Treatemnt Facility	80% after deductible	60% after deductible	
H. Therapies and Rehab Services			
Autism Services	80% after deductible	60% after deductible	Intensive & Non-Intensive

CHOICE 330 PLAN			
Cardiac Rehabilitation	80% after deductible	60% after deductible	
Inhalation Therapy	80% after deductible	60% after deductible	
Physical, Occupational and Speech Therapy	80% after deductible	60% after deductible	Limited to 30 visits per type of therapy, per Calendar Year. Therapy must be to restore loss or correct impairment due to Injury or Sickness.
Pulmonary Rehabilitation	80% after deductible	60% after deductible	
Radiation Therapy	80% after deductible	60% after deductible	
Vision Services	80% after deductible	60% after deductible	
Diagnostic vision services	80% after deductible	60% after deductible	
I. Preventive Care			
Routine Well Adult Care	100%	60% after deductible	See Preventive Care Services under the Medical Benefits section of this document for further details.
Routine Well Newborn/Child Care	100%	60% after deductible	See Preventive Care Services under the Medical Benefits section of this document for further details.
Routine Eye Exam	100%	60% after deductible	Coverage for dependent children through age 18. Adults do not have routine vision coverage.
Flu Shots	100%	60% after deductible	

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT	
Lifetime Maximum Benefit Amount	Unlimited
Annual Maximum Benefit Amount	Unlimited
Deductible Per Calendar Year	None
Maximum Out-of-Pocket Per Plan Year	$ 1,200 Single & Family
NAVITUS NETWORK	
Please consult Navitus Formulary List at https://secure.healthx.com/webtpamember.aspx or contact Navitus Customer Service at (866) 333-2757 to determine the benefit level.	
PHARMACY BENEFIT - 34 Day Supply	
Level 1 Drug (formulary Generic Drugs and specified brand name drugs)	5% Coinsurance
Level 2 Drug (specified Generic Drugs and Formulary Brand Name Drugs)	15% Coinsurance up to a maximum of $125.
Level 3 Drug (Non-Formulary Drugs and Compound Drugs)	40% coinsurance up to a maximum of $125.
PHARMACY BENEFIT - 90 Day Supply	
Level 1 Drug (formulary Generic Drugs and specified brand name drugs)	5% Coinsurance
Level 2 Drug (specified Generic Drugs and Formulary Brand Name Drugs)	15% Coinsurance up to a maximum of $ 325
Level 3 Drug (Non-Formulary Drugs and Compound Drugs)	40% coinsurance up to a maximum of $ 325
MAIL ORDER BENEFIT - 90 Day Supply for Maintenance Medications	
Level 1 Drug (formulary Generic Drugs and specified brand name drugs)	3.5% Coinsurance
Level 2 Drug (specified Generic Drugs and Formulary Brand Name Drugs)	10% Coinsurance up to a maximum of $ 225
Level 3 Drug (Non-Formulary Drugs and Compound Drugs)	40% coinsurance up to a maximum of $ 225
FLU SHOT BENEFIT	
Administered at a Plan Pharmacy	Covered at 100%
Administered at a Non-Network Pharmacy	Covered at 100% with a maximum reimbursement of $25.
Members can access any pharmacy for their flu vaccination needs. Some plan pharmacies are not able to administer the vaccination, please check with your pharmacy to confirm that they are able to administer the vaccine. Some pharmacies may require a prescription to administer the vaccine; details should be available at the pharmacy on any requirements that they may have. Plan pharmacies are able to submit to Navitus for reimbursement and will not require a Member to pay up front for the flu vaccine.	
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	
Refills are available at a retail pharmacy after 75% of the prescribed medication has been used. Refills are available through mail order after 70% of the prescribed medication has been used.	

Additional information on Prescription Drug can be found in the Prescription Drug Benefits section of this document.

NOTE: There is a prescription drug out-of-pocket maximum which may vary annually. Please contact your prescription drug carrier for additional information.

ELIGIBILITY, FUNDING, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A Plan Member should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits, services or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees and Retirees (up to age sixty-five (65) of the Employer.

Effective January 1, 2013, the benefit will be extended to the Domestic Partners of Administrative, Library, Police Union, Fire Union, and DPW Meet and Confer Employees. The same eligibility rules would apply.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least forty (40) hours per week and is on the regular payroll of the Employer for that work.

(2) is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she normally works **at least thirty (30) hours per week** [in accord with PPACA during 180 day look back period] and is on the regular payroll of the Employer for that work.

(3) is a Retired Employee of the Employer.

(4) is in a class eligible for coverage (i.e. Active; COBRA; Early Retiree; Retiree, & Duty Disabled).

(5) completes the following applicable employment Probationary Periods as an Active Employee. A " Probationary Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

GROUP	PROBATIONARY PERIOD	ELIGIBILITY DATE
Administrative, Department of Public Works (Meet and Confer), Library	6 month review period	Your date of hire, if you were hired on or before the 15th day of the month. The first of the month following your date of hire, if you were hired on the 16th day of the month or after.
Fire Fighters	18 months, may be extended an additional six months.	Your date of hire, if you were hired on or before the 15th day of the month. The first of the month following your date of hire, if you were hired on the 16th day of the month or after.
Police Officers	18 months, may be extended an additional six months	Your date of hire, if you were hired on or before the 15th day of the month. The first of the month following your date of hire, if you were hired on the 16th day of the month or after.

Full-Time Transit	At least 120 but not more than 180 consecutive days of regular employment with the Employer.	The first of the month in which you satisfy the Probationary Period, if you were hired or promoted on or before the 15th day of the month. The first of the month following your satisfaction of the Probationary Period, if you were hired or promoted on the 16th day of the month or after. Note: If you are a part-time employee and become a full-time employee at a later date, any time worked as a part-time employee will be credited toward the Probationary Period.
Part-Time Transit (30 hours)	The Probationary Period will not exceed a maximum of six months.	The first of the month in which you satisfy the eligibility period, if you were hired on or before the 15th day of the month. The first of the month following your satisfaction of the eligibility period, if you were hired on the 16th day of the month or after.

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least three (3) but not more than twelve (12) consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods). [In accord with PPACA during 180 day look back period]

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse or Domestic Partner or Employee's Domestic Partner's Child and Employee's children.

An Employee's or Domestic Partner's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The term "Spouse" shall mean the person with whom the covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered Employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal

marital relationship. "Spouse" also includes a lawful domestic partner of a qualifying Employee.

Domestic Partner Definition & Eligibility Rules

Domestic Partners are two individuals who both meet all of the following criteria:

1. Are eighteen (18) years of age or older;
2. Are competent to enter into a contract;
3. Are not married or part of an existing domestic partnership with any third person;
4. Are not related to one another by marriage, or blood closer than permitted under the marriage laws of the State of Wisconsin;
5. Have entered into the Domestic Partnership voluntarily, willingly, and without reservation;
6. Have not entered into the domestic partner relationship for the purpose of obtaining health plan coverage;
7. Have been engaged in a committed relationship with each other for more than eighteen (18) months immediately prior to date of application of coverage;
8. Intend to continue the Domestic Partnership indefinitely, with the understanding that the relationship is terminable at the will of either partner;
9. Consider themselves to be members of each other's immediate family;
10. Are in a mutually exclusive relationship and share responsibility for each other's common welfare, financial obligations, and basic living expenses (proof of such will be required, e.g., ownership of residence, copy of lease, joint checking or savings account);
11. Share a common residence, even if (a.) only one of the individuals has legal ownership of the residence, (b.) one or both of the individuals have one or more additional residences not shared with the other individual; and (c.) one of the individuals leaves the common residence with the intent to return.

The term "children" shall include natural children, adopted children, and children placed with a covered Employee or Domestic Partner in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. A covered Employee's grandchild may be covered if the parent of the child is a covered Dependent who is not yet eighteen (18) years old.

If a covered Employee or Domestic Partner is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents until age twenty-six (26).

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two (2)-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; Foster Children; or any person who is covered under the Plan as an Employee or Retiree.

Dependents are covered only as long as the Active Employee or Retiree is covered.

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

> If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner, or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The City of Janesville shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed, and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization within sixty (60) days from birth. Each Dependent must be enrolled on forms accepted by the Plan Administrator.

To enroll a Domestic Partner, the Employee and Domestic Partner must submit either proof of a Declaration of Domestic Partnership with the Rock County Clerk of the State of Wisconsin, or an Affidavit of Domestic Partnership with the Employer; and an enrollment form. The employee's Employer will complete an Enrollment of a Domestic Partner Checklist. The Employer, or its third party administrator, reserve the right to verify the information provided at any time.

Domestic Partners shall become effective on the same basis as other Qualified Dependents, as described in the Plan Document. The establishment of a Domestic Partner relationship does not have the same legal meaning as marriage. However, the special enrollment provisions applicable as a result of marriage do apply to Domestic Partners or their children (See the Domestic Partner Definition & Eligibility Rules for further details).

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for sixty (60) days. Dependent Coverage **must** be in force for coverage to continue beyond this initial sixty (60) day period. If Dependent coverage is not in force on the last day of the sixty (60) day

period, coverage for the child will immediately terminate. Charges for covered nursery care will be applied toward the Plan of the newborn child.

However, if the Employee makes application for coverage within twelve (12) months of the newborn's date of birth or the adopted child's date of adoption and pays the Plan all back contributions due for the twelve (12) month period of coverage at five and one-half percent (5 ½) interest, coverage for the newborn or adopted child will be effective from the date of birth or adoption.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator within thirty (30) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If the completed form is received by the Plan Administrator more than thirty (30) days after the date you are eligible, this is considered late enrollment and you will not be eligible for medical coverage under this Plan.

If two (2) Employees (the mother and father of the child(ren) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Probationary period as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within thirty (30) days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, meeting qualifications as domestic partners under the City's plan, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty (30) days after the birth, marriage, meeting qualificaitons as domestic partners under the City's plan, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, City of Janesville, 18 N. Jackson Street, P.O. Box 5005, Janesville, Wisconsin, 53547-5005, (608) 755-3080.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Probationary period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) 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.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of 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.

(e) If the other plan contribution exceeds the highest level of the City of Janesville plan contribution, then the Employee can return to the City's Plan.

(f) If the other plan deductible exceeds the highest level of the City of Janesville in-network deductible (i.e., currently the Choice Plan in-network deductible), then the Employee can return to the City of Janesville's Plan.

(g) The Employee or Dependent moves out of the Dean or Alliance Service Area to select another PPO network. *Note: This change is effective 1st of the month after notification.*

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that

does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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 or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a Member under this Plan (or has met the Probationary period applicable to becoming a Member under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period, and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership or affidavit, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. 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 Special Enrollment Period for newly eligible Dependents is a period of thirty (30) days and begins on the date of the marriage, meeting the qualifications as domestic partners under the City's plan, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this thirty (30)-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received; or in the case of domestic partner relationship, on the first day of the first month beginning after the date of registration of the domestic partner relationship or affidavit; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within sixty (60) days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within sixty (60) days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan once the Employee satisfies all of the following

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

NOTE: If the Employee satisfies these requirements between the 1st and the 15th of the qualifying month, then coverage begins the date of hire. If the Employee satisfies these requirements between the 16th and the end of the qualifying month, then coverage begins the first day of the following calendar month.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

1. The completed forms are received by the Plan Administrator within thirty (30) days of the Dependent's eligibility date. This is a timely enrollment. That Dependent is covered on their eligibility date. In the case of a newborn or adopted child, refer to the Effective Date for Newborn and Adopted Children section.

2. The completed forms are received by the Plan Administrator **more than** thirty (30) days after the Dependent's eligibility date. This is a **Late Enrollment**. That Dependent will not be eligible for medical coverage under this Plan.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, such as an intentionally fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was fraudulently obtained or in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for the time of the fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. If intentional fraud is involved, the Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage shall terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The end of the month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days advance written notice of such action.

Termination of Domestic Partnership Coverage
Coverage of a Domestic Partner and his/her dependent children may be terminated at any time upon the completion of a Statement of Termination of Domestic Partnership Coverage signed by the Member. The City of Janesville has extended the right to Domestic Partners and their dependent children for continuation coverage under Federal law.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The end of the calendar month that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The end of the calendar month that covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the last day of the calendar month in which a Dependent child reaches the limiting age as defined by the Plan.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days advance written notice of such action.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993, as from the time amended, as promulgated in regulations issued by the Department of Labor and the State FMLA.

During any leave taken under the Federal or State Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the 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 this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

To be eligible for Family and Medical Leave Act benefits, a City Employee must:

1. work for the city of Janesville;
2. have worked for the city for at least twelve (12) months (need not be consecutive); and
3. have worked for the City at least one thousand two hundred fifty (1,250) hours over the previous twelve (12)months (approximately equivalent to working at least 25 hours per week) for Federal Leave; or one thousand (1,000) hours over the previous fifty-two (52) week period for State Leave. Hours worked under Federal Leave exclude paid time off, unpaid time off, or lay-off, but do include overtime hours worked.

Eligibility is defined by Federal and State law, which may be, from time to time, amended. Eligibility standards may, thus, actually be different than that set forth herein. The eligibility conditions set by law govern.

Federal Family and Medical Leave Entitlement. An eligible City Employee is entitled up to twelve (12) work-weeks in total of unpaid leave during a Calendar Year for one or more of the following reasons:

1. for the birth of the Employee's child;
2. for the placement of a child in the Employee's home by adoption or foster care;
3. Employee entitlement to leave must conclude within twelve (12) months after the child's birth, placement or adoption;
4. to care for an immediate family member (spouse, child, or parent) of the Employee with a serious health condition for whom the Employee has the responsibility of day-to-day care; or
5. to take medical leave when the Employee is unable to work because of a serious health condition.

The City may require the Employee requesting Family Leave to provide documentation of the family relationship. In no event may an Employee take more than a total of twelve (12) weeks of unpaid family or medical leave for any one purpose in a Calendar Year (except for Military Caregiver Leave, please see the Human Resources Office for more information). Spouses employed by the City are jointly entitled to a combined total of up to twelve (12) work weeks of family leave for the birth or placement of a child for adoption or foster care, and to care for a child or parent (but not a parent "in law") who has a serious health condition.

Wisconsin Family & Medical Leave
Please refer to the City of Janesville's policy regarding State Family and Medical Leave Entitlement.

Leave Entitlement

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for benefits for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. The City may offer leave of absences that are more generous than FMLA, under our policies. The Employer has sole discretion over extension of medical benefits for Employees on disability, leave of absence, or layoff. These vary by Employee group and are maintained in writing at the Employer's place of business.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by applicable law. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment probationary period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to one hundred two percent (102%) of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Probationary period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Probationary period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator City of Janesville, 18 N. Jackson Street, P.O. Box 5005, Janesville, Wisconsin, 53547-5005, (608) 755-3080. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Important Notice for Active Employees and Spouses Age sixty-five (65) and Over

An Active Employee that is age sixty-five (65) or over and eligible for Medicare has the option of either:

1. Continuing coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or
2. Electing Medicare coverage as primary, in which case no benefits would be payable under this Plan.

An Active Employee's spouse who is age sixty-five (65) or over and eligible for Medicare has the same option.

Contact your Employer for further information.

SPOUSAL TRANSFER PROVISION

If both spouses are Employees and each has taken single coverage under this Plan, this Plan permits your spouse to take coverage as your Dependent at any time.

In addition, if both spouses are Employees and eligible for coverage under this Plan and your spouse previously waived coverage as an Employee in favor of coverage as your Dependent, this Plan permits your spouse to take coverage as an Employee under the Plan and to enroll you and any other eligible Dependents as Dependents of your spouse when:

1. You and your spouse decide to transfer coverage under the Plan from one spouse to the other;
2. Your spouse decides to take coverage as an Employee for any reason; or
3. You terminate your coverage under the Plan for any reason.

Your spouse must elect coverage under this Plan within thirty (30) days of the date your coverage ends to be a timely enrollment. Your spouse's coverage under this Plan will be effective on the day your coverage ends.

If your spouse applies more than 30 days after the date your coverage ends, you will be Late Applicants under the Plan and will not be eligible for medical coverage under the Plan.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

The Employer has special provisions for not being actively at work. Please refer to the appropriate City Policy, Library Policy or Labor Agreement.

COBRA continuation will be offered at the time your Employer no longer approves the leave.

DUTY RELATED DISABILITY LEAVE

For fire fighters and police officers only, if you are not actively at work as the result of a duty related disability under Wisconsin State Statute 40.65, as from time to time amended, your coverage will remain in force until the end of the month in which *you* reach the age of sixty-five (65). The Employer will continue to pay its portion of the Plan contribution and you must continue to pay the Employee portion of the Plan contribution to maintain coverage.

SURVIVORSHIP CONTINUATION

For active and retired Police Officers and Fire Fighters only, if you have Dependent coverage in force on the date that you die, coverage under this Plan will continue at the Dependent's expense, for your surviving Dependents who were covered under the Plan on the day immediately preceding your death. Survivorship Continuation will end on the earliest of the following:

1. The end of the period for which any required Plan contribution was due and not paid;
2. The end of the month in which the deceased employee would have reached the age of sixty-five (65).

When Survivorship Continuation ends, COBRA Continuation will be offered to any eligible Dependents.

RETIREE COVERAGE

Administrative Employees, Department of Public Works Meet and Confer Group, Fire Fighters, Police Officers, Teamsters and Library Employees

If you are eligible to retire under the Wisconsin Retirement Fund and have not yet reached the age of sixty-five (65), you may be eligible to elect Retiree Coverage under this Plan for yourself and any eligible Dependents. Except as stated below, Retiree Coverage will continue under the Plan until the end of the month in which the retiree reaches the age of sixty-five (65), at which time coverage for you and any dependents will terminate.

Notwithstanding anything in this Plan Document to the contrary, all Administrative employees, DPW Meet & Confer employees, Police Union employees, and Fire Union employees hired on or after January 1, 2016, who become qualified for retiree health plan benefits as set forth by City Policy or Labor Agreement, shall receive not more than ten (10) years of City of Janesville health plan coverage beginning on the employee's date of retirement or until the employee first becomes Medicare eligible, whichever occurs first. This limitation takes effect January 1, 2016, and is subject to

future modification or elimination by the City of Janesville from time to time and at any time. There shall be no exceptions.

If, on the date of your retirement, you are eligible under City Policy or labor agreement to have the Employer continue to pay all or a portion of the Plan premium rate (less the applicable retiree premium contribution), you may elect to maintain coverage under this Plan for you and your Dependents as stated below. In this case only, Retiree Coverage will continue under the Plan as follows:

1. For the retiree under age sixty-five (65):
    - Administrative, DPW Meet and Confer, Fire Fighters, Police Officers, and Teamsters Retirees will be allowed to remain covered until the end of the month in which you reach the age of sixty-five (65).
    - Library Retirees will be offered COBRA coverage for 18 months or until Medicare eligible, whichever comes first.
2. In the case of the retiree reaching age 65:
    - Administrative, DPW Meet and Confer Retirees: Spouse will be allowed to remain covered as long as they pay the full premium rate until the beginning of the month the dependent spouse reaches the age of sixty-five (65).
    - Fire Fighter and Police Officer Retirees: Spouse is offered COBRA coverage for 36 months or until the dependent spouse reaches the age of sixty-five (65), whichever comes first.
    - Teamsters and Library Retirees: Spouse is offered COBRA coverage for 36 months or until Medicare eligible, whichever comes first.
3. .In the case of the retiree's death:
    - Administrative, DPW Meet and Confer Retirees: Spouse will be allowed to remain covered as long as they pay the full premium rate until the later of the date the retiree would have reached the age of sixty-five (65) or the date the dependent spouse reaches the age of sixty-five (65.) COBRA continuation coverage will be offered to any eligible Dependent children.
    - Fire Fighter and Police Officer Retirees: Spouse will be allowed to remain covered as long as they pay the full premium rate until the end of the month in which the retiree would have turned age sixty-five (65). At which time COBRA coverage would be offered for 36 months or until Medicare eligible, whichever comes first.
    - Teamster and Library Retirees: Spouse is offered COBRA coverage for 36 months or until Medicare eligible, whichever comes first.

It is the retiree's or Dependents responsibility to pay the portion of Plan contributions specified by the Employer.

NOTE: If you are a Dependent of a retiree who is Medicare eligible, claims must be submitted to Medicare first for primary payment. After Medicare has processed your claim, the claim and the Medicare EOB (explanation of benefits) should be submitted to this Plan for payment under the provisions of the plan document.

SUMMARY TABLE OF RETIREE UNDER MEDICARE AGE HEALTH PLAN BENEFIT

This table summarizes the differences, if any, in the health plan benefit for retirees under Medicare age. Depending upon the employee group from which you retired and the year in which you retired, you may have a fixed health plan benefit. If so, then the fixed benefit level is indicated in the table below and all other benefits described in the Basic Plan Employee Benefit Manual will apply.

Please Note: For purposes of this table, generic, brand name, brand name on the formulary list, and brand name not on the formulary list will be applied as follows. *Your* pharmacy coverage is dependent upon the medical plan that you selected:

Level 1: Formulary generics and specified brand name drugs.
Level 2: Specified Generic Drugs and Formulary Brand Name Drugs
Level 3: Non-Formulary Drugs and Compound Drugs

Administrative (Non-Union) Retirees, Department of Public Works (Meet and Confer) Retirees

For all retired Administrative and Department of Public Works Meet and Confer retirees, your premium contributions shall increase annually and will be capped at five percent (5%) per year, rounded to the nearest twenty-five ($0.25) cents. Effective January 1, 2005, you are subject to the dental premium copayments as determined by the Employer.

All Administrative and Department of Public Works Meet and Confer retirees are subject to health plan benefit changes. You have the same plan benefits as active employees, including changes in deductibles, scope of coverage, coinsurance, copayments, including prescription drug coinsurance, dental copays and associated costs, subject to the plan option that you select.

Fire Union Retirees

	Retired Prior to 1999	**Retired between 1999 - 2004**	**Retired after 2004**
Plan Options	**EPO Select**	**Choice/EPO, all plan changes apply**	**Choice/EPO, all plan changes apply**
Monthly Premium Contribution	Frozen at Family $10, Single $5	Based on 2004 premium rate with 5% increases every year.	Retiree copay based on year retired, with 5% increases every year.
Monthly Premium Contribution in future years	Frozen at Family $10, Single $5	5% maximum increase per year.	5% maximum increase per year.
Prescription Copay or Coinsurance	Frozen at $6/$10/$10	Pays current coinsurance, see pharmacy section.	Pays current coinsurance, see pharmacy section.
Dental Premium Contribution	None	Pays current contributions.	Pays current contributions.

JPPA Retirees

	Retired Prior to 1997	**Retired between 1997 - 2002**	**Retired between 2003 - 2004**	**Retired in or after 2005**
Plan Options	**Basic**	**Choice/EPO, all plan changes apply**	**Choice/EPO, all plan changes apply**	**Choice/EPO, all plan changes apply**
Monthly Premium Contribution	Frozen at Family $0, Single $0	Frozen based upon the year retired.	Frozen based upon the year retired.	Premium contribution based on year retired, with 5% increases every year.

Monthly Premium Contribution in future years	Frozen at Family $0, Single $0	Frozen based upon the year retired.	Frozen based upon the year retired.	5% maximum increase per year.
Prescription Copay or Coinsurance	Frozen at $2 (all levels)	Frozen based upon the year retired.	Pays current coinsurance, see pharmacy section.	Pays current coinsurance, see pharmacy section.
Dental Premium Contribution	None	None	None	Pays current contribution

Library Retirees

All Library retirees choosing to remain on the City's health plan shall pay the full cost of the health plan option that you select and the full cost of the dental plan.

All Library retirees are subject to health plan benefit changes. You have the same plan benefits as active employees, including changes in deductibles, scope of coverage, coinsurance, copayments, including prescription drug copays, and associated costs, subject to the plan option that you select.

Teamsters Retirees

	All Teamsters Retirees
Plan Options	Choice
Monthly Premium Contribution	Premium Copay based on year of retirement, with 5% increases every year.
Monthly Premium Contribution in future years	5% maximum increase per year.
Prescription Copay or Coinsurance	Pays current coinsurance. See Pharmacy Section
Dental Premium Contribution	Pays current contribution

OPEN ENROLLMENT

Every fall during the annual open enrollment period, covered Employees, and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the Open Enrollment period will become effective January 1 and remain in effect until the following December 31 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Probationary periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

This option is also available to Retirees.

A Plan Member who fails to make an election during the open enrollment period will automatically retain his or her present coverages.

Plan Members will receive detailed information regarding open enrollment from their Employer.

Each year each eligible Employee who is currently enrolled in the City's Plan, who works at least thirty (30) hours per week will be given the opportunity to choose among the various benefit options the Employer offers. Eligible Employees working at least thirty (30) hours per week will be given the opportunity to enroll in the medical benefits of this Plan. Once selections have been made for yourself and any eligible Dependents, the selections are irrevocable until the next annual Enrollment Period or change in status event.

If you are covered under the EPO Plan offered by the Employer and move outside of the EPO service area, you may elect coverage under an alternate plan at the time the change occurs. Credit will be given for the eligibility period to the extent it was satisfied by coverage under the other Employer plan.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Member for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Member that are in excess of any copayments, coinsurance or deductibles, if applicable. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

COVERED CHARGES

All In-Network Covered Charges are reduced per the provider contractual agreements, while Out-of-Network Covered Charges are subject to Usual and Reasonable reimbursement. Once those reductions have been made, Covered Charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board and miscellaneous charges will be payable as shown in the Schedule of Benefits.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The care and treatment of Pregnancy are covered the same as any other Sickness.

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 less than forty-eight (48) hours (or ninety-six (96) hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if it is in lieu of an acute care setting and for skilled versus custodial care, begins within twenty-four (24) hours after discharge from a hospital Confinement or prior Skilled Nursing Facility Confinement and:

(a) and the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the Confinement is needed for further care of the condition that caused the Hospital Confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Reimbursements to In-Network providers will be made in accordance with the fee schedule contained in the agreement that exists between the PPO Network and their contracted providers.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the In-Network provider contractual amount or for Out-of-Network Usual and Reasonable Charge that is allowed for the primary procedures; for each additional procedure performed through the same incision reimbursement will be at fifty percent (50%) of the allowed amount for the initial procedure. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" (i.e. the removal of a healthy appendix during abdominal surgery) and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the In-Network provider contractual amount or for Out-of-Network Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the In-Network provider contractual amount or for Out-of-Network Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed twenty-five (25%) of the surgeon's Usual and Reasonable allowance and ten percent (10%) of the surgeon's In-Network provider contractual amount or for Out-of-Network Usual and Reasonable allowance for Physician's assistant.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility Confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Member's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(7) **Autism Related Covered Expenses:**
Please contact Our Customer Care Center for coordination of care assistance.
Please refer to your Schedule of Benefits for benefit information and limitations.

Services specifically related to a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, Asperger's syndrome and pervasive development disorder not otherwise specified. Verified diagnosis must be conducted by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. For the diagnosis to be valid, the evidence must meet the criteria for autism spectrum disorder in the most recent *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. These services include:

- **Diagnostic testing**, if testing tool is appropriate to the age of the Member and determined through the use of empirically validated tools specific for autism spectrum disorders. We reserve the right to require a second opinion with a provider mutually agreeable to the Member and Us.
- **Intensive-Level services**. The Member is eligible for four (4) years of intensive level services. Any previous intensive-level services received by the Member will be counted against this requirement under this Policy, regardless of payor.

Intensive level services must be consistent with the following:

- Evidence based.
- Provided by a qualified provider as defined by state law.
- Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of twenty (20) or more hours per week over a six (6)-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that the Member be present and engaged in the intervention.
- Provided in an environment most conducive to achieving the goals of the Member's treatment plan
- Includes training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team.
- Commences after an Member is two (2) years of age and before the Member is nine (9) years of age.
- Services must be assessed and documented throughout the course of treatment.
- The Member must be directly observed by the qualified provider at least once every two months.

Nonintensive-Level Services The Member is eligible for nonintensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider or qualified paraprofessional if one of following conditions apply:

- After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level treatment.
- To a Member who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Member's condition.

Nonintensive-Level Services must be consistent with the following:

- The services are based upon a treatment plan and includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
- Provides treatment and services in an environment most conducive to achieving the goals of the Member's treatment plan.

- Provides training and consultation, participation in team meetings and active involvement of the Member's family in order to implement therapeutic goals developed by the team.
- Provides supervision for qualified professionals and paraprofessionals in the treatment team.
- Services must be assessed and documented throughout the course of treatment.

Non-covered Autism Expenses:

- Animal-based therapy including hippotherapy
- Auditory integration training
- Chelation therapy
- Child care fees
- Cost for the facility or location or the use of the facility or location when treatment, therapy or services are provided outside a Member's home.
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Provider travel expenses
- Special diets and supplements
- Therapy, treatment or services to a Member residing in a residential treatment center, inpatient treatment or day treatment facility.
- Prescription Drugs and Durable Medical Equipment**

These items may be covered under the normal terms and conditions of the policy and are not covered under the Autism benefit.

(8) Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

(a) Accidental injury to teeth, Oral Surgery and TMD. There are listed set of dental, accidental injury, oral and temporomandibular disorder (TMD) related services provided under this Document. This plan does not cover other dental or dental-related services except as described below.

i. Dental, extraction of natural teeth, and replacement with artificial teeth due to an accidental Injury.
Covered Expenses:
Tooth extractions, initial repair and/or replacement with artificial teeth, because of an accidental injury.

Evaluation must be sought within seventy-two (72) hours of the accident.

All Medically Necessary hospital or ambulatory surgery center charges incurred, and anesthetics provided in connection with dental care that is provided to a Member in a hospital or ambulatory surgery center, if prior authorized by Quality and Care Management, and if any of the following applies:

- The Member is a child under age seven (7);
- The Member has a chronic disability, or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

To be eligible for coverage, the accident must occur while you are enrolled under this Policy.

A "sound, natural tooth" is a tooth that is fully erupted, has minor restoration that does not compromise the strength and integrity of the tooth structure, lacks clinical evidence of periodontal disease or lacks dental restoration (filling). The tooth must have an excellent long term prognosis.

The term "injured" does not include conditions resulting from eating, chewing or biting

ii. Oral Surgery
Covered Expenses:

- Surgery consult and/or evaluation
- Surgical procedures as follows:
  - Removal of impacted teeth, tumors, and cysts.
  - Treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of mouth.
  - Apicoectomy.
  - Removal of exostoses of the jaw and hard palate.
  - Treatment of fractured facial bones.
  - External and internal incision and drainage of cellulitis.
  - Cutting of accessory sinuses, salivary glands or ducts.
  - Reducing dislocations; alveoloplasty.
  - Frenectomy.
  - Vestibuloplasty.
  - Residual root removal.

iii. Temporomandibular Disorders (TMD)
Covered Expenses:
Diagnostic procedures and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD), if all of the following apply:

- The condition is caused by congenital, developmental or acquired deformity, disease or injury; and
- Under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- Prescribed intraoral splint therapy devices.

Surgical TMD procedures are not subject to the TMD benefit maximum as listed in your Medical Benefits Schedule.

Non-surgical services with a TMD diagnosis code and a plan TMD provider will be subject to the TMD benefit maximum as listed in your Medical Benefits Schedule. Surgical Services will be covered as indicated within the "Hospital & Surgical Services" subsection of this Document.

Non-Covered Expenses for Injury to Teeth, Oral Surgery and TMD*

- All charges or costs exceeding a benefit maximum.
- All dental services, except those listed as covered in this "Accidental Injury to Teeth, Oral Surgery Services and TMD" subsection.

- Surgery performed to correct functional deformities of the mandible or maxilla.
- Correction of malocclusion.
- Hospitalization costs for services not listed in this Section, except those listed in the " Hospital & Surgical Services" subsection, for which Prior Authorization is required.
- Orthodontic care, periodontic care, or general dental care.
- Restoration. Examples include but are not limited to crowns and root canals.
- Tooth damage due to eating, chewing or biting.
- Dental implants.

Please also see Exclusions and Limitations and your Medical Benefits Schedule for any coverage limitations.

(b) **Allergy** testing and treatment.

(c) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Birth Control.** Charges for birth control and contraceptive devices. Specifically excluded are condoms, day after pill and spermicidal gels. Birth Control pills are covered via the prescription carrier.

(f) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Member who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Member provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(g) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan. Phase II, outpatient **cardiac rehabilitation** services.

(h) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(i) **Cochlear implants.** Coverage is for covered Dependent children under the age of eighteen (18) and benefits include surgically implanted auditory devices, including

cochlear implants, bone-anchored hearing aids, middle-ear implantable hearing aids, auditory brainstem implants, and future hearing implants. Bilateral implantation is also covered if an audiologist or surgeon determines it is Medically Necessary

(j) Medically Necessary treatment for **complications** related to a covered medical treatment, including, but not limited to, dental implants.

(k) Initial **contact lenses** or glasses required following cataract surgery or in treatment of an eye injury or disorder as a bandage.

(l) Services of a hospital or ambulatory surgical center, including anesthetics, incurred for **dental care** provided to:

1. a Covered Dependent child under the age of five (5) years,
2. a Member with a chronic disability,
3. a Member with a medical condition which requires hospitalization or general anesthesia for such dental care.

(m) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Installation and use of an insulin infusion pump, other equipment and supplies used in the treatment of diabetes, when not covered under the Prescription Plan and diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year and the pump must be in use for thirty (30) days before purchase. JOBST prescription compression stockings are covered up to two (2) pair per Plan Year.

(n) **Emergency Room** Charges, but only if incurred due to:

- Emergency Accident treatment provided within forty-eight (48) hours of the accident;
- A surgical procedure; or
- Treatment of a Sickness that is a Medical Emergency.

(m) **Habilitative Services:**

Certain services require Prior Authorization from Quality and Care Management. Please contact the Customer Care Center for a current list of services that require Prior Authorization.

Habilitative services and devices are those services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Covered Expenses:

- Physical therapy, occupational therapy and speech therapy.
- Counseling.
- Behavioral health services.
- Services for developmental delay.

Non-Covered Expenses for Habilitative Services:

- Custodial care.
- Daycare.
- Recreational care.
- Respite care.
- Vocational training.
- Prescription drugs and durable medical equipment*.

***These items may be covered under the normal terms and conditions of the Plan and are not covered under the Habilitative benefit.**

(o) **Hearing aids.** For children under 18, coverage is limited to one hearing aid per ear every 36 months. There is no coverage for Adult Members.

(p) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization up to the limits listed in the Schedule of Benefits with the exclusion of prescription drugs.

(q) **Investigational new drugs**, which have reached a Phase 3 clinical investigation for the treatment of HIV infection.

(r) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(s) Treatment of **Mental Disorders and Substance Abuse**. Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or non-quantitative treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. These providers must be credentialed by the network in place and/or the state in which services are rendered.
Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(t) **Nutritional Counseling.** Coverage is provided for health services rendered by a registered dietician, or other licensed provider, for individuals with medical conditions that require a special diet. Some examples of such medical conditions include diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias. Coverage for nutritional counseling is limited to three (3) visits per Member, per Calendar Year. Coverage is not available for made-for-profit entities such as Weight Watchers.

(u) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Charges for Occupational therapy are subject to the limits as described in the Medical Benefits Schedule.

(v) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The following human organ or tissue transplants, when the transplant is provided from a human donor to a living human transplant recipient:

a. bone marrow transplants;
b. heart transplants;
c. heart lung transplants (combined procedures);
d. kidney transplants;
e. liver transplants;
f. lung transplants;
g. pancreas transplants; and
h. pancreas kidney transplants (combined procedures).

SPECIAL TRANSPLANT PROGRAM
In addition to the transplant benefit as stated above, the following benefits are available when the Member(s) is/are accepted to and participate in the Special Transplant Program:

1. Access to Centers of Excellence Transplant Facilities throughout the United States;

2. Reimbursement, up to a total of Five Thousand and 00/100 Dollars ($5,000.00), for expenses incurred by the Member and one companion (two if the patient is a minor child) for:

   a. travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and

   b. lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence;

These benefits are only available when you are accepted and fully participate in the Special Transplant Program and meet the following guidelines:

1. Prior authorization must be obtained from Quality and Care Management at the time of admission for the transplant.

2. All transplant services must be provided at a Centers of Excellence Transplant Facility which participates in this program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from the Employer or Quality and Care Management.

When both the recipient and donor are covered by this Plan, each is entitled to benefits under the Plan.

When only the recipient is covered by the Plan, both the donor and the recipient are entitled to the benefits of the Plan. The donor's benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the Plan.

When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient.

If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue. However, other costs related to the evaluation and procurement are covered for a recipient who is covered under this Plan.

(w) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(x) **Physical therapy** or athletic training by a licensed therapist or licensed athletic trainer if for rehabilitative purposes. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Therapy must be to restore loss or correct impairment due to Injury or Sickness. Services provided for the sole purpose of athletic enhancement will not be covered.

Charges for Physical therapy are subject to the limits as described in the Medical Benefits Schedule.

(y) **Prescription** Drugs (as defined).

(z) **Preventive Care Services.** Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Contraceptives, sterilization procedures, and counseling
    - Approved breastfeeding support, supplies, and counseling.
    - Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  -Diphtheria,
  -Pertussis,
  -Tetanus,
  -Polio,
  -Measles,
  -Mumps,
  -Rubella,
  -Hemophilus influenza b (Hib),
  -Hepatitis B,
  -Varicella
  - Human papillomavirus (HPV)

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(aa) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(bb) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(cc) **Smoking Cessation.** For Members who use tobacco products, up to two (2) tobacco cessation attempts will be covered per Calendar Year under the Medical Plan.

(dd) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

Charges for Speech therapy are subject to the limits as described in the Schedule of Benefits.

(ee) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O., or D.C. Routine or maintenance care is not covered.

(ff) **Sterilization** procedures for covered Employees and Dependent Spouses only.

(gg) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(hh) **Urgent Care.** Services received from an Urgent Care Clinic

(ii) Diagnostic **x-rays.**

QUALITY AND CARE MANAGEMENT SERVICES

Quality and Care Management Services Phone Number

Quality and Care Management
Phone #: (800) 279-1303

The provider, patient or family member must call this number to receive prior authorization of certain Quality and Care Management Services.

You or your provider must call Quality and Care Management at least seven (7) days in advance of any of the non-emergency admissions or outpatient procedures listed below. If admission is on an Emergency basis and with a Out-of-Network provider, Quality and Care Management must be notified within two business days following the admission. You must contact Customer Service at (888) 577-7724 prior to your first visit for any outpatient behavioral health treatment. If your visits are not pre or post certified, benefits will be payable after the non-compliance penalty.

Any costs incurred because of reduced reimbursement due to failure to follow quality and care **management procedures will not accrue toward the one-hundred percent (100%) maximum out-of-pocket payment.**

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Members receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Prior authorization of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

If you have questions about services that require prior authorization, please contact customer service (number on your ID card). Additional information can be obtained about this City of Janesville Choice 330 Plan at deancare.com/ASO/members/aso-medical-management/.

A prior authorization can only be obtained for services that are covered under your Plan benefits. For example, if bariatric surgery is an exclusion of your policy, a prior authorization will not change that exclusion from the Plan. If the services or benefits are covered under your Plan, they are also still subject to any applicable cost sharing (i.e. copays, co-insurance, and deductibles).

Type of Service Requiring Prior Written Authorization (see Quality and Care Management Services Section for additional information)
All **Hospital Admissions** (IP and Observation).
Ambulance transport (Non-emergent)
AODA/Behavior/Mental Health services (Inpatient & Partial Day)
Bariatric Programs and Surgical Services for the diagnosis of Morbid Obesity
Clinical trials
Durable Medical Equipment (DME) >$500; Oxygen does not need a prior authorization

Elective outpatient **Radiology Procedures**: as outlined on deancare.com/ASO/members/aso-medical-management/
Enteral feedings
Genetic Testing
Hearing Aids limited benefit, see Medical Benefit for further details on what is covered.
Home Health Care
Home Infusion
Hospice Services
Medical Injectables
New technologies not commonly accepted as standard of care
Outpatient **hyperbaric chamber**
Some Outpatient surgery procedures per DHP Medical Policies
Pain management outpatient services (including Epidural Steroid Injections)
Physical Therapy (>8 visits)
Potentially **cosmetic procedures**
Prophylactic Mastectomy
Pulmonary Rehabilitation (>24 visits)
Occupational Therapy (>8 visits)
Skilled Nursing Facilities (SNF)
Speech Therapy (after initial visit)
Transplant Services

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Prior authorization of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. 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 prior authorized, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was prior authorized before incurring charges.

The attending Physician does not have to obtain prior authorization 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.

Here's how the program works.

Prior authorization. Before a Member enters a Medical Care Facility on a non-emergency inpatient basis or receives the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, prior authorize the care as appropriate for Plan reimbursement. 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, or on behalf of, the Member. The utilization review administrator can be contacted by calling the telephone number on the Member's ID card **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within forty-eight (48)** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility Confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Member does not receive authorization as explained in this section, the benefit payment will be reduced by twenty percent (20%) up to a maximum of Five Hundred and 00/100 Dollars ($500.00). The penalty is taken prior to applying any deductible, copayments and coinsurance provisions of the Plan, if applicable. The penalty is not applied to the out-of-pocket limit.

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 Member's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Member either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Member to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been prior authorized, 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 Members and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness. Second and/or third opinions rendered by non-plan providers will need prior authorization from Quality and Care Management and may be subject to out-of-area benefits.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Member, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Case Management is free of charge and provides you with a registered nurse who serves as your resource during a time when health care may be challenging or confusing. Your case manager will work with you, your health care provider and other members of the health care team as needed to establish your best plan of care. You may be identified for Case Management based upon a diagnosis, acute injury or from a referral by your health care provider. You also have the option to request Case Management services yourself.

Case Management staff will:

- Ensure you receive the most appropriate health-related services for your condition.
- Create the best plan of care for you in collaboration with your provider and health care team
- Identify high-quality, cost-effective care options
- Find supportive health care and/or community resources
- Offer support and resources to meet your healthcare goals
- Provide education and outreach services to promote a healthy lifestyle

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

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident is a happening by chance and without intention or design. A happening which is unforeseen, unexpected and unusual at the time it occurs.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Amendment is a written document that changes the provisions of the Plan. It must be duly authorized and signed by the Plan Administrator.

Birthing Center means any freestanding 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 laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery Confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator is the person or firm employed by the Plan Administrator to provide clerical services to the Plan. Clerical services include the processing of claims. If the Claims Administrator is not employed by the Plan Administrator, Claims Administrator will mean the Employer.

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

Complications of Pregnancy

1. Medical conditions that are distinct from Pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A non-elective cesarean section surgical procedure;
3. A terminated ectopic Pregnancy; or
4. A spontaneous termination of Pregnancy that occurs during a gestation in which a viable birth is not possible.

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

Confinement means being a resident patient in a Hospital for at least fifteen (15) consecutive hours per day. Being a resident bed patient in a Skilled Nursing Home or other Qualified Treatment Facility twenty four (24) hours a day. Successive Confinements are considered on if:

1. Due to same Injury or Sickness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Custodial Care is care given when the basic goal is to help a person in the activities of daily life (ADL's) and does not require delivery by skilled personnel . These services include but are not limited to assistance for:

- Ambulation
- Bathing, dressing, eating
- Getting out of bed
- Maintenance of bowel and bladder function
- Preparing special diets
- Respite care
- 24-hour supervision for potentially unsafe behavior
- Ostomy care
- Tube and gastrostomy feedings
- Taking medications
- Exercises to improve strength, the loss of which is not attributable to an underlying illness

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. For purposes of this Plan, Employee does not include independent contractors, leased Employees or any Employee who is temporary or seasonal.

Employer is City of Janesville, the sponsor of this self-insured group Plan.

Enrollment Date is the first day of your eligibility period or if earlier, your effective date of coverage under this Plan. If your application is received after the thirty (30) day period for enrollment, you are considered a Late Applicant.

Essential Health Benefits include, to the extent they are covered under the Plan, 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, chronic disease management; and pediatric services, including oral and vision care.

Expense Incurred is the Usual and Reasonable fee charged for services and supplies needed to treat the Injury or Sickness. The date a supply or service is provided is the Expense Incurred date.

Experimental and/or Investigational means services, supplies, care and treatment which does 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.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental 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 decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

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

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required is approved by Medicare.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital Confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises twenty-four (24) hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means. Damage must be due directly and independently of all other causes to an Accident. Muscle tiredness

or soreness is a Sickness under the Plan. Overexertion in an athletic or physical activity is a Sickness under the Plan.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Applicant is an Employee who enrolls for coverage more than thirty (30) days after they are eligible to be covered or a Dependent who is enrolled for coverage more than thirty (30) days after they are eligible to be covered. A Late Applicant will not be enrolled in the plan unless they enroll during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Member. Lifetime limits are waived by the Plan Sponsor.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Condition is a syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Medical Emergency means 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 Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member is any Employee, Retiree or Dependent who is covered under this Plan

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of

Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Member.

Named Fiduciary is the City of Janesville, which has the authority to control and manage the operation of the Plan.

Network - if a provider has contracted with the Network, they are a Network Provider. Network Providers furnish services to the Plan at a negotiated price. If a provider has not contracted with the Network, they are an Out-of-Network Provider

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means City of Janesville Benefit Plan, which is a benefits plan for certain Employees of City of Janesville and is described in this document. The term Plan includes any schedules, attachments and Amendments to the Plan. Prior, current and successive Plans will be considered one Plan and not separate and distinct Plans. This Summary Plan Description provides a description of the Plan.

Plan Administrator is the Employer, who is responsible for the day-to-day functions and engagement of the Plan. The Plan Administrator may employ other persons or firms to process claims and perform other services.

Plan Year is 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.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Qualified Treatment Facility is a facility that is duly licensed and operating within the scope of its license.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means 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 Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or

experience. For In-Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) **Acupuncture.** Acupuncture services unless when used as an anesthetic in place of anesthesia services that would have been covered under the Plan.

(3) **Alternative Treatments-**Any charge for alternative medical treatments. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy, herbal therapy, vitamin therapy, and hypnotherapy.

(4) **Biofeedback,** unless Prior Authorization is obtained.

(5) **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, except as specifically stated under the Covered Charges section of the Plan (e.g. the Cancer Clinical Trial benefit).

(6) **Congenital disease.** Treatment of a congenital disease or anomaly, except to correct a functional defect.

(7) **Cosmetic or plastic surgery.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(8) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(9) **Dental care** or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated. Dental implantology techniques, including prosthetic devices related to such techniques. Coverage for dental implants may be available under this Plan if the loss is due to a covered medical treatment. Non-surgical treatment of any jaw joint problem (except for temporomandibular joint disorder (TMJ), including but not limited to appliances and therapy. Jaw joint problems include: craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and skull; conditions of the facial muscles used in expression or mastication; and symptoms thereof including headaches.

(10) **Educational or vocational testing.** Services for educational, recreational or vocational testing or training.

(11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan. Services provided for the sole purpose of athletic enhancement will not be covered.

(13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

(14) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders and vision therapy (orthoptics). This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(15) **Foot care.** Treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(16) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(17) All **genetic testing and counseling services** are excluded on the Plan. The exception would be for prenatal genetic tests and pharmacological oncology genetic tests.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(20) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(21) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(22) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(23) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(24) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(25) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

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

(27) **Out-of-Network.** Care, treatment, services or supplies rendered by a Out-of-Network provider ***without*** an approved referral from Quality and Care Management.

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Member is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(30) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(31) **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Services excluded include: charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered.

(32) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This will only apply when benefits are available or payable under any Workers' Compensation or Occupational Disease Act or law, regardless of whether a claim was filed for such benefits.

(33) **Over-the-Counter (OTC).** Drugs, food or nutritional supplements, or medical or other supplies that are available without the written prescription of a Physician. OTC items specifically stated in this Plan as a Covered Charge will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a Physician's office, Hospital or other facility it will be covered.

(34) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings (unless prescribed by a Physician), nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(35) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(36) **Primary plan payments.** Any charges that would have been paid by the Member's primary plan, as determined by the Coordination of Benefits rules of this Plan, if the Member had complied with all of the prior authorization requirements of that plan.

(37) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(38) **Prophylactic procedures.** Prophylactic procedures to prevent a Sickness that has not occurred yet; or third party exams, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment, school, travel or the purchase of insurance.

(39) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Member's home or is related to the Member as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(40) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Member's physical condition to make the original device no longer functional or if the existing brace has exceeded it's expected life span and is no longer serviceable.

(41) **Routine care.** Charges for routine or periodic examinations, screening examinations, routine exams required for school, sports or camps, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan, except as specifically described.

(43) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(44) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(45) **Standby surgical team.** Charges for a standby surgical team, unless surgery is actually performed.

(46) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(47) **Surrogate mother.** Treatment, services or supplies for a surrogate mother or any pregnancy resulting from a Member's service as a surrogate mother.

(48) **Telephone, computer or Internet consultations** between the Plan Member and any provider. Completion of claim forms or forms necessary for the Plan Member's return to work or school. Any appointment the Plan Member did not attend.

(49) **Transplants.** Any human organ or tissue transplant except as stated. Any non-human organ transplant. Any artificial organ transplant.

(50) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered

Charge.

(51) **Treatment of an embryo**, zygote or fetus prior to birth. Any procedure, service for supply provided to or for the treatment of an embryo, zygote or fetus prior to birth. This does not include services provided to the mother as part of the mother's prenatal care.

(52) **United States Government owned.** Any service or supply provided in the care of any service related Injury or Sickness (past or present) if the Member is in a Hospital or facility owned or operated by the United States Government or any of its agencies.

(53) **War.** Any loss that is due to a declared or undeclared act of war.

(54) **Weight control or reduction.** Any treatment or services for weight control or reduction. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Card

You will receive an identification (ID) card. It will show your name, ID number and group number.

A complete directory of pharmacies that are part of the Prescription Drug Card service may be accessed online at https://secure.healthx.com/webtpamember.aspx or you may request a copy from the Human Resources Department. The complete directory contains the names of the pharmacies that are part of the Prescription Drug Card by city. The major chains that are part of the complete directory will be provided to you in the pharmacy ID card packet that you receive. Further information on participating pharmacies may be obtained from Navitus at (866) 333-2757, which is available 24 hours per day, 7 days per week. The pharmacy directory is a separate document from this Plan.

How To Use The Prescription Drug Card

Present the ID card and the prescription to a participating pharmacy and pay the pharmacist the coinsurance shown on the Schedule of Benefits. If you have questions, please contact Navitus at:

Navitus Health Solutions
P.O. Box 999
5 Innovation Court
Appleton, WI 54912-0999
(866) 333-2757
https://secure.healthx.com/webtpamember.aspx

Benefits are not available at non-participating pharmacies.

Formulary and Drug Coverage Program

This Plan uses a formulary program to help reduce drug costs and ensure quality. The formulary is a list of preferred brand name drugs and can be accessed online at https://secure.healthx.com/webtpamember.aspx . Please present it to your Physician when drugs are being prescribed. The Plan encourages you to use the formulary whenever possible.

Use of the formulary is on a voluntary basis. However, drugs that are not on the formulary may have higher coinsurance or be excluded, as shown on the Schedule of Benefits.

Prior authorization may be required for certain prescription drugs. A list of prescription drugs requiring prior authorization is available from Navitus or online at https://secure.healthx.com/webtpamember.aspx

Covered Drugs

Benefits are payable for federal legend drugs; Compounded medications of which at least one ingredient is a prescription legend drug. Certain drugs are not covered under the Program, please see exclusions outlined below. Navitus reserves the right to designate certain over-the-counter drugs on the Formulary.

The following medications will be available at no cost to Members beginning January 1, 2013. In order to be covered, each medication will require a Physician's prescription. This prescription, when presented to the pharmacy will allow Members to receive:

- Aspirin to prevent cardiovascular disease in men, ages forty-five (45) to seventy-nine (79); and in women ages fifty-five (55) - seventy-nine (79).
- Oral Fluoride supplements for preschool children older than six (6) months of age.
- Folic Acid supplements for all women planning or capable of Pregnancy.

- Iron supplements for children ages six (6) to twelve (12) months.
- All preferred oral contraceptive products covered on Tier 1 & Tier 2 of the formulary.
- Formulary diaphragms.
- Emergency contraceptives.
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription and over-the-counter medications) for a ninety (90)-day treatment regimen when prescribed by a health care provider without prior authorization will be covered under the Prescription Drug Benefit Plan.
- Coverage for medication for women who are at increased risk for breast cancer and at low risk for adverse medication effects that reduces risk of primary breast cancer in women without cost sharing.

Mail Order Drug Program
If you are using an ongoing prescription drug, you may purchase your medication on a mail order basis. Any drug covered under this Plan may be purchased by mail order, including:

1. Maintenance drugs used to treat an ongoing medical condition and taken on a regular basis; and
2. Injectable insulin, including disposable needles and syringes.

The coinsurance for mail order prescriptions is shown in the Schedule of Benefits. Mail order prescriptions should be sent to:

WelldyneRx
PO Box 3129
Englewood, CO 80155
https://secure.healthx.com/webtpamember.aspx
Alternatively, your Physician may fax in your prescription at (888) 830-3608.

Prior to using the mail order service for the first time, you must register. To register, you must contact the WelldyneRx Customer Service at (866) 490-3326 to obtain an enrollment form, or utilize the mail order form found in the pharmacy ID card packet you receive or at https://secure.healthx.com/webtpamember.aspx .

All prescriptions will be mailed directly to your home. Further information regarding the mail order program may be found at https://secure.healthx.com/webtpamember.aspx .

SPECIAL PHARMACY PROGRAMS

Step Therapy
Step Therapy is a tool that helps ensure patient safety while managing the cost of specific drugs. Step Therapy is used for pre-selected, high-cost drugs that have a high potential for misuse or abuse.

Step Therapy is a "step" approach to providing pharmacy care. This means that specific high-cost medications, based on clinical criteria, are covered by your Plan only after a more appropriate, cost-effective medication has first been tried.

Each Step Therapy recommendation is reviewed by the Navitus Pharmacy and Therapeutics Committee, a committee of Physicians and pharmacists, to ensure safe and effective drug therapy.

Physicians, in most cases, have many drugs from which to choose when writing your prescription. A Step Therapy program supports them in prescribing the most appropriate medications for their patients.

Generic Limit
If you are taking a brand-name drug for which the FDA-approved bioequivalent generic drug is available, then you may continue to take the brand-name drug. However, reimbursement toward your brand-name drug will be limited to the amount the Plan would pay toward the bioequivalent generic.

Tablet Splitting

Tablet splitting of formulary drugs helps control prescription drug benefit costs and can provide significant Savings. Participation in the program is voluntary. Through this program, you pay up to one-half of the usual coinsurance on a select group of prescription drugs. Drugs included in this program are based on Navitus criteria, which are reviewed by the Navitus Pharmacy & Therapeutics Committee.

Exclusions

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration or injection of a covered Prescription Drug.

(2) **Allergens.**

(3) **Appetite suppressants.** A charge for appetite suppressants, drugs for treatment of weight management, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription.

(4) **Blood.** Miscellaneous blood products.

(5) **Compounded Hormone products.** Charges for compounded hormone products.

(6) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(7) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal. Drugs such as Retin A, Tretinoin, Avita, Azelex of Differin may be approved if the Member is over the age of thirty-five (35) and prior authorization has been obtained and Medical Necessity has been established.

(8) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Member.

(9) **FDA.** Any drug not approved by the Food and Drug Administration. Drugs recently approved by the US Food and Drug Administration until reviewed and approved by the Navitus Pharmacy and Therapeutics Committee which determines the therapeutic advantage of the drug and the medically appropriate application.

(10) **Fluoride.** Fluoride products.

(11) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, except when Medically Necessary to treat retarded growth.

(12) **Immunization.** Immunization agents, biological sera, serums, toxoids and vaccines.

(13) **Impotence.** A charge for injectable or non-injectable impotence medication.

(14) **Infertility.** A charge for infertility medication or fertility agents.

(15) **Injectable**. Infusion or injectable medications which are not self-administered.

(16) **Inpatient medication.** Covered prescription medications which are not self-administered or a drug or medicine that is to be taken by the Member, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises, long term care facilities or other inpatient settings.

(17) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(18) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(19) **Miscellaneous.** Miscellaneous supplies and hardware.

(20) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs, even if the patient chooses not to claim such benefits.

(21) **Non-legend/Off-label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses, other than Insulin and Meclizine, or is specifically listed as covered on the Navitus Formulary.

(22) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over-the-counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(23) **Not Medically Necessary.** Charges will be excluded from the Plan if they are not Medically Necessary for the diagnosis and treatment of a Sickness or Injury.

(24) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician. Prescriptions in excess of a thirty-four (34)-day supply (ninety (90)-day for maintenance drugs through the mail order program).

(25) **Rho-D Immune Globulin Human.**

(26) **Workers' Compensation.** Prescription drugs or medicines covered under any Workers' Compensation Law or similar laws.

HOW TO FILE A MEDICAL CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Member is entitled to them.

Each Plan Member will receive a Plan identification (ID) card. It will show the Plan Member's name, group number and effective date of coverage.

All In-Network claims will be handled directly between the PPO Network, Claims Administrator, Dean Health Plan Administrative Services and the provider. If a Plan Member obtains Medical Emergency care outside of their PPONetwork, make sure to show this ID card to the provider. **Dean Health Plan Administrative Services does not require special claim forms.** Please mail the bills directly to Dean Health Plan Administrative Services if the provider does not forward them. Mail the bills to:

Dean Health Plan Administrative Services
P.O. Box 99906
Grapevine, Texas 76099-1808
(888) 577-7724

Be sure each bill show the group number and Plan Member's ID numbers found on the ID card. The Employee's name and patient's name should also be included on each bill.

PAYMENT OF CLAIMS

The Plan will make direct payment to the service provider. If the bill has been paid, please indicate on the original bill "Paid by Employee" and payment will be made to you. The Plan Member will receive a written explanation of payment or reason for denial of any portion of a claim. The Plan reserves the right to request any information required to determine benefits or process a claim. The Plan Member or the service provider will be contacted if additional information is needed to process the claim.

CLAIM FILING LIMITS

You must provide the Plan with written proof of your claim. Proof should be provided within ninety (90) days after the date the claim was incurred. The claim will not be denied if it was not reasonably possible to provide such proof. However, unless you were legally incapacitated during the period, any claim received by the Plan more than fifteen (15) months after the date the claim was incurred will not be covered under the Plan, unless otherwise provided by law or special circumstances are present, e.g. mistake by the Plan or Plan Administrator, or 3rd party.

If the Plan is terminated, written proof of any claims incurred prior to the termination must be given to the Plan within ninety (90) days of its termination. Any claim received by the Plan more than ninety (90) days after it is terminated will not be covered under the Plan.

Claims filed by Exclusive Provider Organizations (EPO) or Participating Provider Organizations (PPO) will be held applicable to their individually contracted filing limits. All other claims should be filed with the Claims Administrator within ninety (90) days from the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced.

CLAIMS APPEAL PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Member may appeal the denial. This appeal provision will allow the Plan Member to:

(a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within one hundred eighty (180) days after the claim payment date or the date of the notification of denial of benefits. If the request for review is not received within one hundred eighty (180)days, your right to appeal the claim denial is forfeited. The written request should be directed to:

Dean Health Plan Administrative Services
P.O. Box 1808
Grapevine, TX 76099-1808

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Member with a written response within sixty (60) days of the date the Plan Administrator receives the Plan Member's written request for review and if not notified, the Plan Member may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within sixty (60) days, the Plan Administrator shall notify the Plan Member of the delay within the sixty (60) day period and shall provide a final written response to the request for review within one hundred twenty (120) days of the date the Plan Administrator received the Plan Member's written request for review.

The Plan Administrator's written response to the Plan Member shall cite the specific Plan provision(s) upon which the denial is based.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." 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 claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal 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.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Claim involving an inpatient stay that has been deemed non-covered also qualifies as an Urgent Care Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. 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.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

These are, for example, Claims subject to Predetermination of Benefits or prior authorization. Please see the Quality and Care Management section of this booklet for further information about Pre-Service Claims.

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

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

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

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written

or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

2) The specific reason or reasons for the adverse determination, 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.

3) Reference to the specific Plan provisions on which the determination was based.

4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

8) Information about the availability of and contact information for, any 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 process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has one hundred eighty (180) days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within thirty (30) days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a

final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

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

1) was relied upon in making the benefit determination;

2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

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

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

2) The specific reason or reasons for the adverse determination, 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.

3) Reference to the specific Plan provisions on which the determination was based.

4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

9) Information about the availability of and contact information for, any 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 process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have forty-eight (48) hours or until the last day of the four (4) month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within ten (10) business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1) The claimant's medical records;

2) The attending health care professional's recommendation;

3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

4) The terms of the Plan;

5) Appropriate practice guidelines;

6) Any applicable clinical review criteria developed and used by the Plan; and

7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within forty-five (45) days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

1) A general description of the reason for the External Review, including information sufficient to identify the claim;

2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

3) References to the evidence or documentation the IRO considered in reaching its decision;

4) A discussion of the principal reason(s) for the IRO's decision;

5) A statement that the determination is binding and that judicial review may be available to the claimant; and

Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final 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.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision 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 original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to both the claimant and the Plan.

Appeals should be sent to:

Dean Health Plan Administrative Services
P.O. Box 1808
Grapevine, TX 76099-1808

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This Plan's benefits are coordinated with benefits provided by other plans that provide additional coverage to a Member. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this Plan. This provision will apply whether or not the Member files a claim under any other plan that covers the Member.

Effect on Benefits
In certain cases, this Plan's benefits will be reduced when the Member is covered by other plans that provide benefits for the same service. Benefits under this Plan and any other plans, as defined below, will be coordinated. The total benefit will not exceed one hundred percent (100%) of the total Covered Charge(s) incurred under this Plan.

Definitions
A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the Member's membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefit Works
One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Covered Charge(s). These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the Usual and Reasonable value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination
The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.

2. The plan that covers the person as an Employee will be primary.

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents, rule 3 will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In this case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents;

    a. the plan of a parent who has primary physical placement will be primary,
    b. the plan of a step-parent that has primary physical placement will pay benefits next,
    c. the plan of a parent who does not have primary physical placement will pay benefits next, and
    d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

    Unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:
    a. The plan of a parent who has primary physical placement will pay the benefits first,
    b. The plan of a parent who does not have primary physical placement will pay benefits next,
    c. The plan of a grandparent whose child has primary physical placement will pay benefits next,
    d. The plan of a grandparent whose child does not have primary physical placement will pay benefits next.

    If the primary plan is not established by the above rules, the plan that has covered the grandparent or parent for the longest period will be primary.

7. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee.

8. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons an active employee or the dependent of an active employee.
    a. Disability extension employee is considered an active employee with benefits paying as primary until WRS disability is approved. After the approval of disability the employee will be considered an Early Retiree and the Plan will pay as secondary, as the situation described in #7 above.

9. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of

benefit rules, the Plan will never pay more than fifty percent (50%) of Allowable Charges when paying secondary.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If a plan other than this Plan does not Coordinate Benefits according to the above, then that provision will be waived in order to determine benefits with the other plan.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Coordination of Benefits between Medical and Dental Plans
In all cases, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare
In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage if Medicare would be considered primary. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Your benefits under this Plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

Coordination of Benefits with Tricare
The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Member may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Member may have a claim against that Third Party, or insurer, including but not limited to the Member's insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Member may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Member has against any Third Party, or insurer, whether or not the Member chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Member whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full. This Plan is not intended to serve as a supplement to, or replacement for, any payments or benefits a Member has or may recover from any Third Party, or insurer of the Third Party, when charges are incurred as the result of an accident, Illness, Injury or other medical condition caused by an act or omission of said Third Party.

The payment for benefits received by a Member under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Member as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Member, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Member to the payments of those benefits.

The Member:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Member agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a one hundred percent (100%), first dollar priority over any and all Recoveries and funds paid by a Third Party to a Member relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Member may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Member's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Member. Also, the Plan's right to Subrogation still applies if the Recovery received by the Member is less than the claimed damage, and, as a result, the claimant is not made whole. Further, the Plan's Recovery shall not be reduced due to the Member's own negligence.

The Plan will not pay for any fees or costs associated with a claim or lawsuit, unless the Plan provides its prior, express written approval.

When a right of Recovery exists, the Member will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Member will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Member if a Member refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Member is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Member or his authorized legal representative obtains valid court recognition and approval of the Plan's one hundred percent (100%), first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Member" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Member or his or her designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Member's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including, but not limited to, another person or a business entity.

Recovery from another plan under which the Member is covered. This right of Refund also applies when a Member Recovers under an uninsured or underinsured motorist plan or "no-fault" or automobile medical payment plan (all of which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under City of Janesville Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members 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 Janesville, 18 N. Jackson Street, P.O. Box 5005, Janesville, Wisconsin, 53547-5005, (608) 755-3080. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Members who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Members 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).

Who can become a Qualified Beneficiary? 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 who otherwise qualifies as a Qualified Beneficiary 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 who otherwise qualifies as a Qualified Beneficiary 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.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of

such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes 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., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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 nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner and their dependent child(ren) are considered 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.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Member 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. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Dependent of a Retiree or Employee loses coverage due to the Employee or Retiree'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) unless otherwise covered.

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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 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"), as amended, 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. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee separates employment or is no longer considered as a Plan eligible employee.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to one hundred two percent (102%) of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within thirty (30) days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires Members to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the 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.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 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. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing 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 to the Plan Sponsor.

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:

City of Janesville
18 N. Jackson Street
Janesville, Wisconsin 53547

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, for example, 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 you or your 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.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? 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.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? 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 enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(5) 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, for example, 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.

What are the 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 bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or thirty-six (36) months after the death of the retiree.

(4) 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.

(5) 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.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an eighteen (18)-month or 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) -months 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 and with respect to 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 Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a 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 Plan Sponsor in accordance with the procedures above.

Does the Plan require 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 one hundred two percent (102%) of the applicable premium and up to one hundred fifty percent (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.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for 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 Fifty and 00/100 Dollars ($50.00) or ten percent (10%) of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the 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 YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The City of Janesville's Benefit Plan is a plan maintained for the eligible Employees, Dependents and Retirees of the City of Janesville. The Plan Administrator is also called the Plan Sponsor. An individual, or entity, may be appointed by City of Janesville to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Janesville shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Member's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

(8) To retain experts to assist the administration in discharging its responsibilities.

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain Members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any Member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the

past, present or future physical or mental health or condition of an individual, including Genetic Information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to Members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of Genetic Information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to Members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "Participant of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the Participant of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized Participant of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any Participant of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan Member in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan Members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible; and

(j) Ensure the adequate separation between the Plan and Members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of City of Janesville's workforce are designated as authorized to receive Protected Health Information from City of Janesville Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resources and Administration.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set

out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

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

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

City of Janesville Benefit Plan- CHOICE

TAX ID NUMBER: 39-6005472

PLAN EFFECTIVE DATE: January 1, 2013

RESTATED EFFECTIVE DATE: January 1, 2017

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

Physical Address:

City of Janesville
18 N. Jackson Street
Janesville, Wisconsin 53545
(608) 755-3080

Post Office Box:

City of Janesville
P.O. Box 5005
Janesville, Wisconsin 53547-5005
(608) 755-3080

PLAN ADMINISTRATOR

Physical Address:

City of Janesville
18 N. Jackson Street
Janesville, Wisconsin 53545
(608) 755-3080

Post Office Box:

City of Janesville
P.O. Box 5005
Janesville, Wisconsin 53547-5005

CLAIMS ADMINISTRATOR

Dean Health Plan Administrative Services
P.O. Box 99906
Grapevine, Texas 76099-1808
(888) 577-7724

PRESCRIPTION DRUG CARD PROGRAM

Navitus Health Solutions
P.O. Box 99
5 Innovation Court
Appleton, WI 54912-0999
https://secure.healthx.com/webtpamember.aspx

BY THIS AGREEMENT, City of Janesville Choice 330 Benefit Plan is hereby adopted as shown.

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

By Susan A Musick
City of Janesville

Date 31 October 2016

Witness Julie A Parker

Date 10/31/2016