



CITY OF GREEN BAY POINT OF SERVICE PLAN 3

Health Benefit Summary Plan Description

**Effective 01-01-2008
Revised 01-01-2010, 01-01-2011,
01-01-2012**

BENEFITS ADMINISTERED BY



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CITY OF GREEN BAY
GROUP HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. As a valued employee of CITY OF GREEN BAY, We are pleased to provide You with benefits that can help meet Your health care needs.

CITY OF GREEN BAY is named the Plan Administrator for this group health plan. The Plan Administrator has retained the services of two independent Claim Administrators to process claims and handle other duties for this self-funded Plan. The Claim Administrators for this Plan are WPS Health Plan, Inc. d/b/a Arise Administrators (henceforth "Arise Administrators") for medical claims, and Prescription Solutions/Optum Rx for pharmacy claims. The Claim Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Employer assumes the sole responsibility for funding the employee benefits out of general assets. However, employees help cover some of the costs of covered benefits through premiums, Deductibles, Copays, and participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with a capital letter, even though it normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group health plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits, and remedies available for appeal of claims denied are outlined in the following pages of this booklet. Please read this document carefully and contact Your supervisor or Human Resources Department if You have questions.

If You haven't already received this, You will be getting an Identification Card that You should present to the provider when You receive services. This card also has phone numbers on the back of the card so You know who to call if You have questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD").

This document originally became effective on January 1, 2008 and has been revised effective January 1, 2010, January 1, 2011, and January 1, 2012.

BENEFIT CLASS DESCRIPTION

Your benefit class is determined by the designations shown below:

Division	<u>Class Description</u>	<u>Benefit Plan</u>
0025	ALL ACTIVE WATER EMPLOYEES PARTICIPATING IN PLAN 3	Plan 3
0026	ALL RETIRED WATER EMPLOYEES PARTICIPATING IN PLAN 3	Plan 3
0027	ALL ACTIVE CITY EMPLOYEES PARTICIPATING IN PLAN 3	Plan 3
0028	ALL RETIRED CITY EMPLOYEES PARTICIPATING IN PLAN 3	Plan 3
0029	ALL COBRA PARTICIPANTS PARTICIPATING IN PLAN 3	Plan 3

SCHEDULE OF BENEFITS

Benefit Plan 3

All health benefits shown on this Schedule of Benefits are subject to the individual annual maximums, individual and family Deductibles, Copays, participation rates, and out-of-pocket maximums, and are subject to all provisions of this Plan including Medical Necessity, Exclusions, and any other benefit determination based on an evaluation of medical facts.

Note: Certain covered services require certification before benefits will be considered for payment. Failure to obtain certification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this document for a description of these services and certification procedures.

THE TRANSPLANT BENEFIT IS INSURED AND ADMINISTERED BY UNITED RESOURCE NETWORKS (URN) MANAGED TRANSPLANT PROGRAM. ARISE ADMINISTRATORS DOES NOT ADMINISTER THE TRANSPLANT PROVISION AND DOES NOT HANDLE ANY CLAIMS OR APPEALS RELATED TO TRANSPLANT ISSUES. PLEASE REFER TO YOUR FULLY INSURED TRANSPLANT POLICY FOR TRANSPLANT PLAN BENEFITS.

SUMMARY OF BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Annual Deductible per calendar year: <ul style="list-style-type: none"> • Per Person • Per Family 	\$150 \$450	\$300 \$900
Participation rate, unless otherwise stated below: <ul style="list-style-type: none"> • Paid by Plan after satisfaction of Deductible 	100%	65%
Annual Out-Of-Pocket maximum: <ul style="list-style-type: none"> • Per Person • Per Family 	\$150 \$450	\$900 \$2,700
Ambulance and other Medically Necessary Emergency transportation (ground and air): <ul style="list-style-type: none"> • Paid by Plan after Deductible • Maximum benefit for air ambulance • Maximum benefit for ground ambulance 	100% \$2,000 Fee charged by the City of Green Bay	100% \$2,000 Fee charged by the City of Green Bay
Autism Spectrum Disorders <ul style="list-style-type: none"> • Paid by Plan after Deductible • Maximum benefit per calendar year for Intensive-Level Services • Maximum benefit per calendar year for Nonintensive-Level Services 	100%	65% \$51,700 \$25,850
Chiropractic Services: <ul style="list-style-type: none"> • Separate Deductible • Individual • Family • Paid by Plan after Deductible (Chiropractic charges do not apply to the out-of-pocket maximums and will always remain at 80%.) (This includes massage therapy if performed by a Chiropractor and custom made orthotics if prescribed by a Chiropractor.)	\$100 \$300 80%	\$100 \$300 80%
Contraceptive Devices <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%

SUMMARY OF BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Durable Medical Equipment: <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%
Extended Care Facility Benefits such as skilled nursing, convalescent, or subacute facility: <ul style="list-style-type: none"> • Paid by Plan after Deductible – 1st 30 days per confinement • 180 day separation between confinements • Paid by Plan after Deductible– 90 additional days per confinement 	100%	65%
Hearing Aids and Cochlear Implants for children under the age of 18 <ul style="list-style-type: none"> • Paid by Plan after Deductible • Coverage of hearing aids will be limited to the cost of one hearing aid every three years per ear per Dependent under age 18 	100%	65%
Home Health Care Benefits: <ul style="list-style-type: none"> • Paid by Plan after Deductible • Maximum visits per calendar year 	100%	65% 40 visits
Hospice Care Benefits: <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%
Hospital Services including physician services while in the Hospital (except for mental health and substance abuse): <ul style="list-style-type: none"> • Paid by Plan after Deductible Emergency Room: <ul style="list-style-type: none"> • Paid by Plan after Participating Deductible and Coinsurance Inpatient (Room and Board subject to the payment of semi-private room rate): <ul style="list-style-type: none"> • Paid by Plan after Deductible Outpatient: <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%
Mental Health Benefits: Inpatient or Partial Hospitalization: <ul style="list-style-type: none"> • Paid by Plan after Deductible Outpatient treatment: <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%
Oral Surgery Benefits: <ul style="list-style-type: none"> • Paid by Plan after Deductible 	100%	65%
Orthotics (custom made only): <ul style="list-style-type: none"> • Paid by Plan after Deductible (Not including custom made orthotics prescribed by a Chiropractor.)	100%	65%

SUMMARY OF BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Physician Services (including mental health and substance abuse): Office visit: <ul style="list-style-type: none"> Copay per office visit Maximum office visit Copays per calendar year <ul style="list-style-type: none"> Paid by Plan after Deductible 	\$15 100%	\$15 3 for a single plan 7 for a family plan 65%
Preventive Care Benefits, Birth to Age 6: <ul style="list-style-type: none"> Immunizations as State Statutes require (Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus Influenza B, Hepatitis B, Varicella, Rotavirus, Pneumococcal) <ul style="list-style-type: none"> Paid by Plan 	100%	100%
Preventive Care Benefits (any routine procedures for all ages and immunizations): <ul style="list-style-type: none"> Routine physical Routine pap smear Routine eye exam and glaucoma testing (without refraction) Routine mammogram Routine colorectal cancer screenings Preventive services rated A or B by the United States Preventive Services Task Force Immunizations as recommended by the Advisory Committee on Immunization Practices <ul style="list-style-type: none"> Paid by Plan 	100%	65%
Substance Abuse and Chemical Dependency Benefits: Inpatient or Partial Hospitalization: <ul style="list-style-type: none"> Paid by Plan after Deductible Outpatient treatment: <ul style="list-style-type: none"> Paid by Plan after Deductible 	100%	65%
Temporomandibular Joint Disorder benefits: <ul style="list-style-type: none"> Paid by Plan after Deductible 	100%	65%
Therapy (Outpatient treatment for Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy.) (Massage Therapy if performed by MD or Physical Therapist.): <ul style="list-style-type: none"> Paid by Plan after Deductible 	100%	65%
All Other Covered Expenses: <ul style="list-style-type: none"> Paid by Plan after Deductible 	100%	65%

All Non-Participating Provider services are subject to Usual and Customary payment maximums. Charges over Usual and Customary are the patient's responsibility and are not applied to annual out-of-pocket maximums.

If the Arise Administrators network does not have a particular type of specialist in their network, a Participant who required that type of specialist and used such a specialist who is a Non-Participating Provider would be eligible for benefits at the Participating Provider level.

PRESCRIPTION BENEFITS SUMMARY PRESCRIPTION BENEFITS ADMINISTRATION (PRESCRIPTION SOLUTIONS/OPTUM RX) Benefit Plan 3	
By Participating Retail Pharmacy Your Copayment per prescription or refill—up to a 34 day supply Generic Preferred Brand Non-Preferred Brand Preventive Care Drug	\$ 5.00 \$15.00 \$25.00 \$0
Blood Factor Products	100%
Rx OTC Program (Alavert and Prilosec OTC)	\$0
By Participating Retail Pharmacy Your Copayment per prescription maintenance products—up to a 102 day supply. Generic Preferred Brand Non-Preferred Brand Preventive Care Drug	\$15.00 \$45.00 \$75.00 \$0
By Participating Mail Order Pharmacy Your Copayment per prescription maintenance products—up to a 90 day supply. Generic Preferred Brand Non-Preferred Brand Preventive Care Drug	\$ 5.00 \$15.00 \$25.00 \$0
By Specialty Pharmacy Vendor Your Copayment per prescription or refill—up to a 34 day supply Generic Preferred Brand Non-Preferred Brand	\$ 5.00 \$15.00 \$25.00
By Non-Participating Pharmacy	You will need to pay for the prescription up front, and then submit a written request to Prescription Solutions/Optum Rx for reimbursement. You can be reimbursed for covered prescription products up to the contracted rate of a Participating Pharmacy.
Out-of-Pocket maximum per Employee or Family per calendar year	\$1,000

The participant will be charged the difference in cost between a Generic product and Brand product when the Physician has not required a Brand product.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

COPAYS

A Copay is the amount that the Covered Person must pay to the provider each time certain services are received. Copays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Copay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a calendar year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new calendar year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise.

Only Covered Expenses will count toward meeting the Deductible. Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at a Participating or Non-Participating Provider) will be used to satisfy the total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a calendar year and applied toward satisfaction of the individual Deductible for that year, will also be applied toward the individual Deductible requirement for the next year.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that calendar year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses, until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, negotiated rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the calendar year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as Copays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Copays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this SPD.
- Copays and Participation amounts for Prescription products.
- Any amounts over the Usual and Customary amount, negotiated rate, or established fee schedule that this Plan pays.
- Chiropractic charges.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at a Participating or Non-Participating Provider) will be used to satisfy the total out-of-pocket maximum.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

- If You are employed on the first through the fifth day of the month, You are eligible for coverage on Your employment date.
- If You are employed on the sixth through the thirty-first day of the month, You are eligible for coverage on the first of the month following Your employment date.
- If You are a permanent part-time employee, You are eligible for benefits per Your employment contract.

The start of Your Waiting Period is the date of hire for the job that made You eligible for coverage under this Plan.

A Waiting Period will not count against You or Your Dependents for purposes of counting Creditable Coverage. It is not considered a break in coverage.

ELIGIBILITY REQUIREMENTS

An **Eligible Employee** is a person who is a regular Employee as determined by the employer, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased Employees.
- An Independent Contractor.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An **eligible Dependent** includes:

- Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act. An eligible Dependent does not include an individual from whom You

have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- Your child until the end of the month in which the child reaches his or her 26th birthday.
- Your child who has turned age 26 on or before **December 31, 2011** will be covered until the end of the calendar year in which the child reaches his or her 27th birthday.
- A grandchild as long as the Employee's covered Dependent is the parent of the grandchild. Coverage for the grandchild will end when the Employee's covered Dependent (parent of child) turns age 18.

The term "**child**" includes the following children:

- A natural, biological child;
- A step child;
- A legally adopted child or a child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 18 as of the date of such placement;
- A child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
- A child who is considered an alternate recipient under a Qualified Medical Child Support Order.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

Coverage under this Plan may be extended for a Dependent child if one of the following conditions is met:

- An adult child who is attending a licensed trade school or an Accredited Institution of Higher Education as a Full-time Student will continue to be eligible regardless of age provided that the adult child meets all of the following eligibility criteria:
 1. The child was called to federal active duty in the national guard or in a reserve component of the United States armed forces while the child was attending, on a full-time basis, an institution of higher education; and
 2. The child was under the age of 27 when called to federal active duty; and
 3. The child returned to school as a Full-Time Student within 12 months from the date he or she fulfilled his or her active duty obligation.

If the child is called to federal active duty more than once within a four (4) year period of time, the child's age at the time of their first call to federal active duty will be used when determining eligibility under this Plan.

Once such adult child is no longer attending school as a Full-Time Student, he or she will no longer be eligible for coverage under this Plan. However, if such adult child ceases to be a Full-Time Student due to a Medical Necessary leave of absence and this Medically Necessary leave of absence is documented and certified by such child's physician, coverage will continue until the earlier of the date:

1. The adult child advised us that he or she does not intend to return to school full time; or
2. The adult child becomes employed full time; or
3. The adult child obtains other health care coverage; or
4. The adult child marries and is eligible for coverage under his or her spouse's health care coverage; or
5. Your coverage is discontinued or not renewed; or
6. One year has elapsed from the date the adult child ceased to be a Full-Time Student and the adult child has not returned to school full time.

Extended coverage for such adult children will terminate at the end of the month that the adult child is no longer attending or enrolled as a Full-Time Student, unless the adult child is on a Medically Necessary leave of absence, will terminate on August 31st if the adult child graduates from the spring or summer semester, or will terminate on December 31st if the adult child graduates from the fall semester. The Plan may require proof of the adult child's Full-Time Student enrollment on an as-needed basis. A Full-Time Student who finishes the spring term shall be deemed a Full-Time Student throughout the summer if the Student has enrolled as a Full-Time Student for the following fall term, regardless of whether or not such Student enrolls for the summer term.

Such adult child may enroll in the Plan at the beginning of the semester if the adult child qualifies due to initial or re-enrollment as a Full-Time Student. For the purposes of the Plan, the beginning of the semester is deemed to be the date classes resume for the fall semester and spring semester; or

- If You have a Dependent child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that child's health coverage may continue beyond the day the child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:
 - The Dependent Child is dependent on You and Your spouse for more than half of his or her support; and
 - The Dependent must not be able to hold a self-sustaining job due to the disability; and
 - Proof must be submitted as required; and
 - The Employee must still be covered under this Plan; and
 - The incapacity existed on the date of attainment of the limiting age.

A Dependent child who has not attained the age of 26 may re-enroll in the Plan subject to the Plan terms if the Dependent child becomes Totally Disabled.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in the Extended Coverage for Dependent Children section. If, at any time, the Dependent fails to attend school as a Full-Time Student for reasons other than a Medically Necessary leave of absence, or the Dependent does not meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If Your completed enrollment forms are received by Your employer before Your eligibility date, Your coverage is effective on Your eligibility date.
- If Your completed enrollment forms are received by Your employer after Your eligibility date, but within 30 days from that date, Your coverage is effective on Your eligibility date.
- If Your completed enrollment forms are received by Your employer within 60 days after loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP, Your coverage is effective on the first day of the month following the date enrollment forms are received.
- If Your completed enrollment forms are received by Your employer within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP, has been

determined, Your coverage is effective on the first day of the month following the date enrollment forms are received.

- If Your completed forms are received by Your employer more than 30 days after Your eligibility date, or after 60 days after loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP or after 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP, has been determined, and the Special Enrollment Provision is not applicable, You are considered a Late Enrollee. You will not be eligible for coverage until the next Annual Enrollment Period.
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date of marriage if application is made within 30 days of the date of marriage; or
- The date You acquire Your Dependent if application is made within 30 days of birth, adoption, placement for adoption, or appointment of legal guardianship as ordered by a court; or
- The first day of the month coinciding with or following the date an enrollment application is received if application is made within 60 days after loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP; or
- The first day of the month coinciding with or following the date an enrollment application is received if application is made within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP, has been determined; or
- Your Dependent will be considered a Late Enrollee if the Special Enrollment Provision is not applicable and You request coverage for Your Dependent more than 30 days after Your hire date, more than 30 days following the Dependent's birth, adoption, placement for adoption, or appointment of Legal Guardianship as ordered by a court, more than 30 days after Your date of marriage, more than 60 days after loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP, or more than 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP, has been determined. That Dependent will not be eligible for coverage until the next Annual Enrollment Period; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The date specified in a Qualified Medical Child Support Order.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL ENROLLMENT PERIOD

This Plan offers an Annual Enrollment Period each year to allow Late Enrollees to enroll in the Plan. The Annual Enrollment Period occurs during the month of November. Coverage will become effective on January 1st of the following year.

Completed enrollment forms must be received by the employer before the end of the Annual Enrollment Period. If Your completed enrollment forms are not received by that time, You will not be able to enroll in the Plan until the next Annual Enrollment Period, unless the Special Enrollment Provision applies.

TERMINATION

Please see the COBRA section of this SPD for questions regarding coverage continuation.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the last calendar month for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
 - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons or are on temporary lay-off, Your coverage under this Plan will continue during that leave as approved by the City of Green Bay on a non-discriminatory basis.
 - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
- The last day of the month in which Your employment ends.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the last calendar month for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except in the event that the Employee dies. Coverage for the surviving spouse can continue following the death of the Employee until the date of the surviving spouse's death, on attainment of age 65, or the date of remarriage, provided that the surviving spouse pays the applicable contribution when due. Coverage for Your Dependent child can continue following the death of the Employee as long as the surviving spouse remains covered under the Plan; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The end of the month in which Your Dependent child turns age 26, unless the child qualifies for Extended Coverage for Dependent Children; or
- The end of the calendar year in which Your Dependent reaches his or her 27th birthday if such child had turned age 26 on or before December 31, 2011; or
- If Your adult child qualifies for Extended Coverage for Dependent Children as a Full-Time Student, coverage terminates on the last day of the month in which Your adult child no longer qualifies as a Full-Time Student, unless the adult child is on a Medically Necessary leave of absence, on August

31st if the adult child graduates from the spring or summer semester, or on December 31st if the adult child graduates from the fall semester; or

- If Your Dependent child qualifies for Extended Coverage for Dependent Children as Totally Disabled, coverage terminates the last day of the month in which Your Dependent child is no longer deemed Totally Disabled under the terms of the Plan; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status or special enrollment; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, or lay-off and You later return to active work, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources Department.

EXTENSION OF BENEFITS

INDIVIDUAL TERMINATION

If You or Your Dependents are confined in a hospital on the date on which Your coverage terminates, hospital benefits shall continue to be available until that confinement terminates or benefits are exhausted.

ENTIRE PLAN TERMINATION

In the event that You or Your Dependent are Totally Disabled on the date the Plan is terminated, the Plan will continue to provide benefits until the end of the disability or until the applicable benefit limit is reached, whichever occurs first, but in no event beyond 90 consecutive days for benefits **other** than Major Sickness coverage or beyond 12 consecutive months for Major Sickness Benefit.

RETIREE COVERAGE

If You retire before age 65, You may continue coverage up to age 65. If You retire at age 65 or later, You may continue coverage under this Plan for up to 18 months under COBRA.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated employees.

LOSS OF HEALTH COVERAGE

Current employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage. Your loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time You declined coverage. The Plan will not recognize Your special enrollment right due to a loss of coverage if other coverage was not in effect at the time You declined enrollment. You declined enrollment if You do not enroll in the Plan when first eligible, during a special enrollment period, or upon COBRA being offered.

You and/or Your Dependents may enroll for health coverage under this Plan due to loss of other health coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- You and/or Your Dependents stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Your coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact; or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption, or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period.

You must request and apply for coverage within 30 calendar days of marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of loss of coverage, on the date following loss of coverage.

PRE-EXISTING CONDITION PROVISION (Applies to Late Enrollees only)

A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care, or treatment was recommended or received within six consecutive months prior to the Covered Person's Enrollment Date. Medical advice, diagnosis, care, or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition for 18 consecutive months beginning on the Enrollment Date. Charges incurred after such 18 month period are eligible for benefits as provided under this Plan. This 18 month period will be reduced by Creditable Coverage as described below.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- Any person who, on the Enrollment Date, had 18 consecutive months of Creditable Coverage.
- Pregnancy, including complications.
- A newborn Dependent child if application for enrollment is made within 30 days of birth, or if any Creditable Coverage is obtained for the newborn within 30 days after the date of birth.
- An adopted Dependent child or Dependent child Placed for Adoption under the age of 18, if application for enrollment is made within 30 days of adoption or Placement for Adoption, or if any Creditable Coverage is obtained for the Dependent child within 30 days of adoption or Placement for Adoption.
- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.
- A Covered Person who is under the age of 19.
- A Retiree who is coming back onto the Plan.

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION TIME PERIOD (Creditable Coverage)

If, on the Enrollment Date, a Covered Person has less than 18 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies.

Creditable Coverage means that You had coverage under a group health plan, health insurance policy, Medicare, or any one of several other health plans as described in the Glossary of Terms section of this document, and Your coverage was not interrupted by a Significant Break in Coverage.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-Existing Condition exclusion time period. Waiting Periods will not count towards a Significant Break in Coverage. In addition, the days between the date an individual loses health care coverage and the first day of the second COBRA election period under the Trade Act of 2002 will not count towards a Significant Break in Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

New employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the person's prior employer or insurance company as soon as possible. If You are having difficulty getting this, contact Your PRIOR Human Resources or Personnel office for assistance regarding coverage that existed prior to this Plan.

In addition, Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

ARISE ADMINISTRATORS
BILLING & ENROLLMENT DEPT.
P.O. BOX 11625
GREEN BAY, WI 54307-1625

You are encouraged to keep these Certificates in a safe place in case You get coverage under another health plan that has a Pre-Existing Condition Provision. By proving that You had prior Creditable Coverage, You may be able to have the Pre-Existing Condition exclusion period reduced or eliminated.

YOUR RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If You feel that a determination of a Pre-Existing Condition exclusion (PCE) period is incorrect, You may submit a written request for review.

Send Your request to:

ARISE ADMINISTRATORS
BILLING & ENROLLMENT DEPT.
P.O. BOX 11625
GREEN BAY, WI 54307-1625

Your written request must be made within 60 days from the date of the notice. However, if Your request is based on additional evidence that shows that You had more Creditable Coverage than recognized originally, You may take longer.

Your written request should state the reasons that You believe the original determination is incorrect and include any additional facts that support Your position. You should submit any additional evidence that shows that You had more Creditable Coverage.

Your request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, You will be notified. You will be notified in writing of the decision on Your request if You submit additional evidence to consider or if the original Determination of PCE period is modified. If You do not receive notice of a decision within 60 calendar days after You submit the request, this means that the original decision was upheld.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand Your COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides You with general notice of Your rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You as required.

The COBRA Administrator for this Plan is: CITY OF GREEN BAY

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage triggers COBRA.

Generally, You, Your covered spouse, and Dependent children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18 month period of COBRA continuation coverage can be extended. See the section below entitled "Your Right to Extend Coverage" for more information.)

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from your spouse	up to 36 months

The Dependent children of an Employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA NOTICE PROCEDURES

ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrator, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify Your COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number;
- The group number and name of the employer that the Employee was with;
- Description of the Qualifying Event (i.e., the life event experienced); and
- The date that the Qualifying Event occurred.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

**CITY OF GREEN BAY
HUMAN RESOURCES
100 N JEFFERSON ST RM 500
GREEN BAY WI 54301**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

You must give notice in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a dependent child ceasing to be covered under a plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to Your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

Once You have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If You do not choose COBRA continuation coverage within the 60-day election period, Your group health coverage will end on the day of Your Qualifying Event.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive on or after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group health coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time Your coverage under the Plan would have otherwise terminated, up to the time You make the first payment. If the initial payment is not made within the 45-day period, then Your coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, You will receive specific payment information, including due dates, when You become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then You will be required to reimburse the Plan for the benefits received.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

YOUR NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is **required within 30 calendar days of**:

- The date any Qualified Beneficiary gets married. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.
- The date a child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- The date the COBRA Administrator or the Plan Administrator requests additional information from You. You must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - Employee's death;
 - Employee's divorce or legal separation;
 - Former Employee becomes enrolled in Medicare; or
 - A Dependent child no longer being a Dependent as defined in the Plan.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): In the event that You are determined by the Social Security Administration to be disabled, You may be eligible for up to 29 months of COBRA continuation coverage.

You must give the COBRA Administrator the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent children if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both), is divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent. These events will only lead to the extension when the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

You must provide the notice of a second Qualifying Event within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that You are under, but still maintains another group health plan for other similarly-situated Employees, You will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the Qualified Beneficiary.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If You Are Thinking Of Declining COBRA Continuation Coverage)

If You think You might need to get an **individual health insurance policy** soon, then electing COBRA continuation coverage now may protect some of Your rights. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, You must elect COBRA continuation coverage under this Plan and maintain it (by paying the cost of coverage) for the duration of Your COBRA continuation period. In the event that You need an individual health insurance policy, You must apply for coverage with an individual insurance carrier after You have exhausted Your COBRA continuation coverage and before You have a 63-day break in coverage.

If You think You will be getting **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if You have less than a 63-day break in health coverage (Creditable Coverage).

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee, or the Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- The covered former Employee becomes enrolled in Medicare.
- A Dependent child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

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

COVERAGE

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

- 24 months beginning on the day that the Uniformed Service leave begins; or
- A period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

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

PROVIDER NETWORK

Your coverage provides for the use of a Point of Service (POS) plan. Certain benefits are paid at different levels if the service is not provided by a Participating Provider. The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Expense, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is a Non-Participating Provider, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Participation level with the Covered Person being responsible for a larger percentage of the total medical expense.

A **Participating Provider** is a person or entity who has entered into a written agreement with WPS Health Plan, Inc. d/b/a Arise Administrators and has agreed to provide services to covered individuals for the fees negotiated in the provider agreement. This negotiated fee arrangement is followed by the Plan instead of the Usual and Customary requirement.

A **Non-Participating Provider** is a person or entity who has not entered into a written agreement with WPS Health Plan, Inc. d/b/a Arise Administrators and has not agreed to accept the fees that the Plan pays for covered services. A Non-Participating Provider may bill You for additional fees over and above what the Plan pays, and charges will be subject to the Plan's Usual and Customary limitations.

Note that a facility may have both Participating Providers and Non-Participating Providers at the same location, so You will want to review the Provider Directory or ask Your provider if they are a Participating Provider or not. The participation status of providers may change from time to time.

The Primary Point of Service Network for Your coverage under this Plan is:

WPS Health Plan, Inc. d/b/a Arise Administrators Network with Beechstreet/Viant Travel Network

For Transplant Services at a Designated Transplant Facility, the Network is:

United Resource Networks (URN) Managed Transplant Program

List of Participating Providers Under the Point of Service Plan:

Upon request, each covered Employee, those on COBRA, and children or guardians of children who are considered alternate recipients under a Qualified Medical Child Support Order will be given or electronically sent a separate document, at no cost that lists the Participating Providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they can request this in writing from the Plan Administrator. The Plan Administrator may assess a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

It is Your responsibility to make sure the provider is a Participating Provider.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are Medically Necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other plan provisions shown in this document. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve or improve the Covered Person's condition or that maximum medical improvement has been reached.

1. **Ambulance Transportation:** Medically Necessary and Emergency ground and air transportation to the nearest medically appropriate Hospital.
2. **Anesthetics** and their administration.
3. **Artificial Limbs, Eyes, and Larynx** when Medically Necessary for Activities of Daily Living as a result of an Illness or Injury.
4. **Autism Services** (Refer to Autism Spectrum Disorders Section).
5. **Cardiac Rehabilitation:**
 - Phase I, while the Covered Person is an Inpatient.
 - Phase II, while the Covered Person is Outpatient. Services generally begin within 30 days after discharge from the Hospital.
6. **Chiropractic Treatment** by a Qualified Chiropractor or licensed Osteopath, which includes the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference or related to distortion, misalignment, or subluxation of the vertebrae column.
7. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pregraft palatal expander.
8. **Contraceptives or Contraceptive Devices** for the prevention of pregnancy or for other Medically Necessary purposes.
9. **Colorectal Cancer Screenings** at recommended ages and intervals for participants determined to be at high risk for developing colorectal cancer. Please see Preventive Services and Well Person Physical Exams for coverage of preventive colorectal cancer screenings. The following factors will be used in determining whether a participant is at high risk for colorectal cancer:
 - Personal history of colorectal cancer, polyps, or chronic inflammatory bowel disease.
 - Strong family history in a first-degree relative or two or more second-degree relatives of colorectal cancer or polyps.
 - Personal history or family history in a first or second-degree relative of hereditary colorectal cancer syndromes.
 - Other conditions, symptoms, or diseases that are recognized as elevating one's risk for colorectal cancer as determined by the United States Preventive Services Task Force.
10. **Cosmetic or Reconstructive Surgery** only if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury.
11. **Crutches** (the lesser of rental or purchase price).
12. **Dental:** (also refer to Oral Surgery information)

- The care and treatment of teeth and gums if an Injury is sustained in an Accident, excluding implants.
- Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the Hospital.
- Extraction and initial replacement of natural teeth.

13. **Diabetic Supplies** with a written prescription:

- Blood glucose monitors (excluding attachments).
- Insulin Pump.

14. **Drugs** that are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's prescription.

(Refer to the Pharmacy Benefits section for coverage if You have a written Physician's prescription and obtain medication from a pharmacy).

15. **Durable Medical Equipment:** The lesser of the rental or purchase price of wheelchairs, hospital-type beds, oxygen equipment (including oxygen), and other Durable Medical Equipment, subject to the following:

- The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury and will be provided on a rental basis for the period of treatment. At the Plan's option, such equipment may be purchased. If the equipment is purchased, benefits may be payable for subsequent repairs including batteries or replacement only if required:
 - due to the growth or development of a Dependent child;
 - when Medically Necessary because of a change in the Covered Person's physical condition; or
 - because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.
- Benefits will be limited to standard models, as determined by the Plan.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair, or motorized scooter, unless Medically Necessary due to growth of the person or changes to medical condition require a different product as determined by the Plan.
- Custom made orthotics.

16. **Extended Care Facility Services:** Must be certified in advance by Arise Administrators on behalf of the Plan. (Refer to the Utilization Management Section)

- Room and board.
- Miscellaneous services, supplies, and treatments provided by an Extended Care Facility.

17. **Eye Diseases:** Protective lenses following a cataract operation.

18. **Hearing Deficit:**

- Exams, tests, services, and supplies, for other than preventive care, to diagnose and treat a medical condition.
- Cochlear implants and related treatment.
- Hearing aids for children under the age of 18. Coverage for hearing aids will be limited to the cost of one hearing aid every three years per ear per Dependent under age 18.

19. **Home Health Care Services:** (Refer to Home Health Care section).

20. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility and can include:

- **Assessment:** Includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care to meet those needs.
- **Inpatient Care:** In a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian; part-time nursing care by or supervised by a registered nurse for up to 8 hours per day.
- **Hospice Counseling:** Counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and the immediate family, limited to 15 visits per family.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist, or psychiatrist. The services must be furnished within six months of death. Benefit maximum of \$100 per Covered Person.

Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

21. **Hospital Services (includes Inpatient services, Ambulatory Surgery Centers, and Birthing Centers):**

- Semi-Private Room and Board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the hospital has private rooms only, coverage will be for the price of the most common room rate.
- Intensive Care Unit Room and Board.
- Miscellaneous and ancillary services.
- Blood, blood plasma, and plasma expanders when not available without charge.
- Nutrition counseling.

22. **Hospital Services (Outpatient).**

23. **Immunosuppressive agents.**

24. **Joint Replacements.**

25. **Laboratory Tests** for covered benefits.

26. **Maternity Benefits** for covered members include:

- Prenatal and postnatal care
- Hospital room and board
- Obstetrical fees for routine prenatal care
- Vaginal delivery or Cesarean section
- Medically Necessary diagnostic testing (such as ultrasound and amniocentesis)
- Abdominal operation for intrauterine pregnancy or miscarriage

27. **Medical Foods** prescribed by a Physician, consumed or administered under the supervision of a Physician, which are not available over the counter through commercial sources, and where life would be threatened or substantial disability risked if such Medical Food were not consumed.
28. **Mental Health Treatment** (Refer to Mental Health Section).
29. **Morbid Obesity Treatment** includes tests or treatments that are Medically Necessary and appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

This Plan does not cover diet supplements, exercise equipment, or any other items listed in the General Exclusions.

30. **Nursery and Newborn Expenses Including Circumcision** are covered for:

- Natural (biologic) children of all Covered Persons.

If a newborn has an illness, suffers injury, premature birth, congenital abnormality, or requires care other than routine care, benefits will be provided on the same basis as for any other Covered Expense if coverage is in effect for the baby.

31. **Oral Surgical Procedures** limited to:

- Excision of partially or completely unerupted impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery, and grafting) to treat gingivitis or periodontitis.
- Apicoectomy (the excision of the tooth root without the extraction of the entire tooth).
- Root canal therapy, if performed in conjunction with an apicoectomy.
- Excision of exostosis of jaws and hard palate.
- Alveolectomy (leveling of structures supporting teeth for the purpose other than the fitting of dentures), but is not payable if performed in conjunction with routine extraction of natural teeth.
- Functional Osteotomies.

32. **Orthopedic Shoes with Attached Leg Brace.**

33. **Oxygen and Its Administration.**

34. **Physician Services** for covered benefits.

- **Physician Assistant** paid at 10% of primary Physician's Usual and Customary charge.

35. **Prescription Medication and Product Coverage** (Refer to Prescription Benefit section).

36. **Preventive Services and Well Person Physical Exams** as listed under the Schedule of Benefits.

- Immunizations as recommended by the Advisory Committee on Immunization Practices.
- Routine mammogram.
- Routine pap test.
- Routine eye exam and glaucoma testing.

- Routine colorectal cancer screenings for persons age 50 and over subject to the appropriate time intervals that are recommended by the United States Preventive Services Task Force. The screening tests or procedures include fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy.
- Preventive services rated A or B by the United States Preventive Services Task Force.

37. **Radiation Therapy and Chemotherapy.**

38. **Reconstructive Surgery Following a Mastectomy** (Women's Health and Cancer Rights Act): The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and complications of mastectomies, including lymphedemas.

39. **Sterilizations (Voluntary).**

40. **Substance Abuse Services** (Refer to Substance Abuse section).

41. **Surgery and Surgery Centers and Assistant Surgeon Services** if determined Medically Necessary by the Plan.

- For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and fifty percent (50%) of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.
- **Assistant Surgeon** paid at 20% of primary surgeon's Usual and Customary charge.

42. **Temporomandibular Joint Disorder (TMJ) Services:** Benefits will be provided for the surgical and non-surgical treatment of TMJ. Surgical treatment is covered as any other Illness. Covered services include intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension. TMJ shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly. This does not cover orthodontic services.

43. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational Therapy** by a Qualified occupational therapist.
- **Physical Therapy** by a Qualified physical therapist.
- **Speech Therapy** by a Qualified speech therapist.
- **Respiratory Therapy** by a Qualified respiratory therapist.
- **Massage Therapy** by a Qualified MD, chiropractor, or physical therapist.

This Plan does not cover services that should legally be provided by a school.

44. **X-ray Services** for covered benefits.

45. **Worldwide Protection:** This health plan pays for reasonable charges anywhere in the world. Arise Administrators will determine reasonable charges in areas where care was provided.

AUTISM SPECTRUM DISORDERS

Coverage will be provided for services rendered to a Covered Person that has a primary verified diagnosis of Autism Spectrum Disorder, as determined by Us. We will also provide coverage for diagnostic testing for Autism Spectrum Disorders. In order for the diagnosis to be valid for Autism Spectrum Disorder, the testing tools used must be appropriate to the presenting characteristics and age of the Covered Person and be empirically validated for Autism Spectrum Disorders to provide evidence that the Covered Person meets the criteria for Autism Spectrum Disorders in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

We may, at Our expense, require a Covered Person to obtain a second opinion from another provider experienced in the use of empirically validated tools specific for Autism Spectrum Disorders who is mutually agreeable to both You and Us. Coverage for the cost of a second opinion will be in addition to the benefit mandated by Section 632.895(12m), Wisconsin Statutes, as amended.

Coverage provided for Autism Spectrum Disorders will not be subject to the general Limitations or Exclusions under this Plan. However, the Maximum Benefit Limit need not be met if it is determined by the supervising professional, in consultation with the Covered Person's physician, that less treatment is medically appropriate.

Benefits under this provision do not include benefits for Durable Medical Equipment or Prescription Drugs. For coverage of these items, please see the Durable Medical Equipment (DME), Supplies, and Prosthesis provision and the Prescription Drug Benefit Section.

Definitions

Autism Spectrum Disorder means autism disorder, Asperger's syndrome, or pervasive development disorder not otherwise specified.

Behavior Analyst means a person certified by the Behavior Analyst Certification Board, Inc., or successor organization, as a board-certified Behavior Analyst and has been granted a license under Section 440.312, Wisconsin Statutes, to engage in the Practice of Behavior Analysis.

Behavioral means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

Evidence-Based Therapy means therapy, service, and treatment that is based upon medical and scientific evidence, is determined to be an efficacious treatment or strategy, and is prescribed to improve the Covered Person's condition or to achieve social, cognitive, communicative, self-care, or behavioral goals that are clearly defined within the Covered Person's treatment plan. To be considered an efficacious treatment or strategy, the therapy must be designed to:

- A. Address cognitive, social, or behavioral conditions associated with Autism Spectrum Disorders;
- B. Sustain and maximize gains made during Intensive-Level Services; or
- C. Improve an individual with Autism Spectrum Disorder's condition.

Intensive-Level Services means evidence-based Behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social, and behavioral deficits associated with that disorder. These therapies must be directly based on, and related to, a Covered Person's therapeutic goals and skills as prescribed by a physician familiar with the Covered Person. Intensive-Level Services may include evidence-based speech therapy and occupational therapy provided by a Qualified Therapist when such therapy is based on, or related to, a Covered Person's therapeutic goals and skills and is concomitant with evidence-based Behavioral therapy.

Nonintensive-Level Services means Evidence-Based Therapies that occur after the completion of treatment with Intensive-Level Services and that are designed to sustain and maximize gains made during treatment with Intensive-Level Services or, for an individual who has not and will not receive Intensive-Level Services, Evidence-Based Therapies that will improve the individual's condition.

Practice of Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to produce socially significant improvements in human behavior, including the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis, including interventions based on scientific research and the direct observation and measurement of behavior and environment. Practice of Behavior Analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, marriage counseling, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

Qualified Intensive-Level Professional means an individual working under the Supervision of an Outpatient Mental Health Clinic who is a licensed treatment professional as defined in Section DHS 35.03(9g), Wis. Admin. Code, and who has completed at least 2,080 hours of training, education, and experience including all of the following:

- A. 1,500 hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, efficacious therapy models;
- B. Supervised experience with all of the following:
 - 1. Working with families as part of a treatment team and ensuring treatment compliance;
 - 2. Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - 3. Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges;
 - 4. Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
 - 5. Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders; and
- C. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

Qualified Intensive-Level Provider means an individual identified in Section 632.895(12m)(b) 1. to 4., Wisconsin Statutes, acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides Evidence-Based Behavioral therapy in accordance with this provision and Section 632.895(12m)(a) 3., Wisconsin Statutes, and who has completed at least 2,080 hours of training, education, and experience which includes all of the following:

- A. 1,500 hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, efficacious therapy models;
- B. Supervised experience with all of the following:
 - 1. Working with families as the primary provider and ensuring treatment compliance;
 - 2. Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - 3. Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges;
 - 4. Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
 - 5. Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders; and

- C. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

Qualified Paraprofessional means an individual working under the active supervision of a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Provider and who complies with all of the following:

- A. Is at least 18 years of age;
- B. Obtains a high school diploma;
- C. Completes a criminal background check;
- D. Obtains at least 20 hours of training that includes subjects related to Autism Spectrum Disorders, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;
- E. Obtains at least 10 hours of training in the use of Behavioral Evidence-Based Therapy including the direct application of training techniques with an individual who has Autism Spectrum Disorder present; and
- F. Receives regular, scheduled oversight by a Qualified Supervising Provider in implementing the treatment plan for the Covered Person.

Qualified Professional means a professional acting under the Supervision of an Outpatient Mental Health Clinic certified under Section 51.038, Wisconsin Statutes, acting within the scope of a currently valid state-issued license and who provides Evidence-Based Therapy in accordance with this provision.

Qualified Provider means an individual acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides Evidence-Based Therapy in accordance with this provision.

Qualified Supervising Provider means a Qualified Intensive-Level Provider who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals, and paraprofessionals.

Qualified Therapist means an individual who is either a speech-language pathologist or occupational therapist acting within the scope of a currently valid state-issued license and who provides Evidence-Based Therapy in accordance with this provision.

Supervision of an Outpatient Mental Health Clinic means an individual who meets the requirements of a Qualified Supervising Provider and who periodically reviews all treatment plans developed by Qualified Professionals for Covered Persons with Autism Spectrum Disorders.

Waiver Program means services provided by the Wisconsin Department of Health Services through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare and Medicaid Services.

Intensive-Level Services Benefit

Benefits are payable for charges for evidence-based Behavioral Intensive-Level Services, the majority of which are provided to the Covered Person when a parent or legal guardian is present and engaged in the therapy. The therapy must be prescribed by a physician and must meet all of the following requirements:

- A. Therapy must be based upon a treatment plan developed by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional that includes at least 20 hours per week over a six-month period of time of evidence-based Behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly

observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Covered Person to be present and engaged in the intervention;

- B. Therapy must be implemented by Qualified Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals;
- C. Therapy must be provided in an environment that is most conducive to achieving the goals of the Covered Person's treatment plan;
- D. Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Covered Person's family;
- E. Therapy must begin after a Covered Person is two years of age and before he or she is nine years of age; and
- F. Therapy must be provided by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional who directly observes the Covered Person at least once every two months.

Progress must be assessed and documented throughout the course of treatment. We may, at Our option, request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Coverage for Intensive-Level Services will be provided for up to 48 months. We may, at Our option, credit against the required 48 months of Intensive-Level Services any previous Intensive-Level Services the Covered Person may have received prior to enrolling under this Plan. We may require documentation, including medical records and treatment plans, to verify any evidence-based Behavioral therapy that the Covered Person received for Autism Spectrum Disorders that was provided prior to the Covered Person attaining nine years of age. We may consider any evidence-based Behavioral therapy that was provided to the Covered Person for an average of 20 or more hours per week over a continuous six-month period to be Intensive-Level Services.

Travel time for providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

Benefits are also payable for charges of a Qualified Therapist when services are rendered concomitant with Intensive-Level evidence-based Behavioral therapy and all of the following:

- A. The Qualified Therapist provides Evidence-Based Therapy to the Covered Person who has a primary diagnosis of an Autism Spectrum Disorder;
- B. The Covered Person is actively receiving Behavioral services from a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional; and
- C. The Qualified Therapist develops and implements a treatment plan consistent with their license.

Please refer to the Schedule of Benefits for the maximum benefit for Intensive-Level Services.

Nonintensive-Level Services Benefit

Covered Expenses are payable for evidence-based Nonintensive-Level Services, including direct or consultative services, that are provided to a Covered Person by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional either after the completion of Intensive-Level Services to sustain and maximize gains made during Intensive-Level Services or provided to a Covered Person who has not and will not receive Intensive-Level Services but for whom Nonintensive-Level Services will improve the Covered Person's condition. Nonintensive-Level Services must meet all of the following requirements:

- A. Therapy must be based upon a treatment plan developed by a Qualified Provider, Qualified Professional, or Qualified Therapist that includes specific Evidence-Based Therapy goals that are clearly defined, directly observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Covered Person to be present and engaged in the intervention;
- B. Therapy must be implemented by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional;
- C. Therapy must be provided in an environment most conducive to achieving the goals of the Covered Person's treatment plan; and
- D. Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Covered Person's family.

Progress must be assessed and documented throughout the course of treatment. We may, at Our option, request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Travel time for providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

Please refer to the Schedule of Benefits for the maximum benefit for Nonintensive-Level Services.

Transition to Nonintensive-Level Service

We will provide notice to You regarding a change in the Covered Person's level of treatment. The notice will indicate the reason for transition that may include any of the following:

- A. The Covered Person has received 48 cumulative months of Intensive-Level Services;
- B. The Covered Person no longer requires Intensive-Level Services based on supporting documentation from a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Intensive-Level Professional; or
- C. The Covered Person is no longer receiving evidence-based Behavioral therapy for at least 20 hours per week over a six-month period of time.

Notice Requirement

You must notify Us at any time in which a Covered Person requires and qualifies for Intensive-Level Services but is unable to receive Intensive-Level Services for an extended period of time. You must indicate the specific reason(s) in which You or the Covered Person are unable to comply with the Intensive-Level Services treatment plan. Reasons for requesting Intensive-Level Services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event, or any other reason that We determine to be acceptable.

We will not deny Intensive-Level Services provided to a Covered Person for failing to maintain at least 20 hours per week of evidence-based Behavioral therapy over a six-month period of time when You provide the notice required under this section or when You can document that the failure to maintain at least 20 hours per week of evidence-based Behavioral therapy was due to waiting for Waiver Program services.

Non-Covered Services

This Plan will not pay for expenses incurred for the following:

- A. Acupuncture.
- B. Animal-based therapy, including hippotherapy.
- C. Auditory integration training.
- D. Chelation therapy.
- E. Child care fees.
- F. Cranial sacral therapy.
- G. Custodial or respite care.
- H. Hyperbaric oxygen therapy.
- I. Special diets or supplements.
- J. Claims that have been determined by Us to be fraudulent.
- K. Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals.
- L. Treatment rendered by a parent or legal guardian who is otherwise considered a Qualified Provider, Qualified Supervising Provider, Qualified Therapist, Qualified Professional, or Qualified Paraprofessional when the treatment is rendered to his or her own children.
- M. Therapy, treatment, or services provided to a Covered Person who is residing in a residential treatment center, Inpatient treatment facility, or day treatment facility.
- N. Costs for a facility or location or use of a facility or location when treatment, services, or Evidence-Based Therapy are provided outside of the Covered Person's home.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by Arise Administrators. You must be certified in advance by Arise Administrators before receiving services. Please refer to the Utilization Management Section for more details. Covered services that are Medically Necessary include:

- Home visits that are in lieu of visits to the Provider's office and that do not exceed the Usual and Customary charge to perform the same service in a Provider's office.
- Intermittent Nurse Services. Benefits paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Intermittent care or services by a licensed nurse midwife.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing Intermittent Nurse Services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

If you are eligible for Medicare, home health care visits under this Plan will be continued beyond those provided by Parts A and B of Title XVIII of the Social Security Act sufficient to produce an aggregate coverage of 365 home care visits per calendar year.

EXCLUSIONS

In addition to the General Exclusions listed later in this document, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services except as ordered in the Hospice treatment plan.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers without causing undue hardship.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living such as food, clothing, and household supplies.
- Legal and financial counseling services.
- Home Health Care will not be reimbursed unless the qualified practitioner certifies that hospitalization or confinement in a skilled nursing facility would otherwise be required if home care were not provided.

PRESCRIPTION BENEFIT PROVISION

The Pharmacy Benefits Administrator for this Plan is: Prescription Solutions/Optum Rx

NOTE: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. You may be able to postpone enrollment in the Medicare Prescription Drug coverage if Your current drug coverage is at least as good as Medicare Prescription Drug coverage. If You decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, You may have to pay an additional monthly penalty if You change Your mind and sign up later. You should have received a Notice telling You whether Your current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. If You need a copy of this notice, please contact Your Plan Administrator.

DEFINITIONS

Blood Factor Products means blood coagulation factors used for the treatment of hereditary coagulation disorders (i.e., hemophilia).

Brand Product means a brand name or trademark name which is typically the originator of the product. A brand status is determined by First Data Bank or any other industry source. Brand status may change depending on the cost of the product as issued by the manufacturer.

Contracted Amount means the discounted amount negotiated by the Pharmacy Benefits Administrator with the Plan that is providing the Prescription benefit. This amount may include applicable sales tax and pharmacy dispensing fees associated with the dispensing of any Prescription.

Generic Product means a non-Brand Product, which is a pharmaceutical equivalent to a Brand Product, but is typically sold at a lower cost. The generic status is determined by First Data Bank or any other industry source. Generic status often changes depending on the cost of the product as issued by the manufacturer.

Medical Professional means any person licensed under the laws of any state to prescribe and administer Medicines and supplies.

Medicine or Medication means a substance or preparation that alleviates or treats a sickness, disease, or Injury and may be available by Prescription only or over-the-counter (OTC). Medicine includes only substances and preparations that qualify as medical care under the Internal Revenue Code §213. In general, medical care means care for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Non-Prescription Drugs means an over-the-counter (OTC) Medication or supply normally purchased without a Prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements and statutes and regulations of any state and the federal government.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by the Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy and Therapeutics Committee is a committee comprised of independent Physicians and pharmacists organized by the Pharmacy Benefits Administrator that meets on a quarterly basis to review Medications and supplies.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Products List means a list of products that have been determined by the Pharmacy and Therapeutics Committee to be clinically appropriate for reimbursement at the "Preferred" level of benefits as indicated in the Prescription Benefits Summary. The Pharmacy and Therapeutics Committee will review and modify this list periodically as new information becomes available. The Pharmacy Benefits Administrator will make available a copy of the Preferred Products List to the Plan, providers, Covered Persons, and pharmacists.

Prescription means any order authorized by a Medical Professional for a Prescription or Non-Prescription Drug that could be a Medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the Medical Professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the Medication or supply prescribed.

Prescription Drug means licensed Medicine that is regulated by legislation and requires a Prescription before it can be obtained.

Prescription Maintenance Products mean products prescribed by a Physician, which are needed on a long-term basis, usually for treatment of a chronic or degenerative health condition, and are able to be safely prescribed in up to a three-month supply.

Preventive Care Drug means a Prescription Drug whose routine use is rated A or B by the United States Preventive Services Task Force (USPSTF). These drugs require a written Prescription from a Medical Professional and are limited to the following:

- Aspirin for the prevention of cardiovascular disease;
- Fluoride supplements for children older than 6 months;
- Iron supplements for asymptomatic children aged 6-12 months;
- Folic acid for women planning or capable of pregnancy; and
- Prophylactic medication for gonococcal ophthalmia neonatorum.

Prior Authorization means if Your Medical Professional believes that You need a Prescription product that is on the Prior Authorization List, or is not covered for other reasons, he or she may contact the Pharmacy Benefits Administrator to request the Plan's review of the situation. Your Medical Professional will provide the Pharmacy Benefits Administrator required information on Your medical condition, so the Plan can properly evaluate Your need for the requested products. Upon review by a licensed pharmacist, the Pharmacy Benefits Administrator may do one of the following:

- Approve the Medical Professional's request and authorize coverage of this Medication for a certain period of time at the appropriate Copay.
- Recommend an alternate Medication for consideration by the Medical Professional.
- Deny the request to cover the requested Medication.

If the Prescription Medication that You need requires Prior Authorization and You can't wait for the Prior Authorization review to take place, You can ask Your Medical Professional if a drug sample is available, or Your pharmacy may provide You with a short-term supply (such as a 5-day supply) while the Prior Authorization review is taking place. You will be responsible for the Copay at this time. This Copay will not be credited toward this Prescription if dispensed on a later date.

Prior Authorization List means a list of Prescription products that are FDA (Food and Drug Administration) approved for a specific diagnosis or as second line therapy, identified by the Pharmacy and Therapeutics Committee for which the Pharmacy Benefits Administrator requires information from the Medical Professional to determine the appropriate level of coverage. The Pharmacy and Therapeutics Committee or Pharmacy Benefits Administrator will review and modify this list periodically as new information becomes available.

Quantity Limits means limiting the dispensing quantities applied to Medications that are appropriate for acute use. Quantity Limits are designed to provide sufficient amounts for the treatment of one or more acute episodes. Quantity Limits are established based on FDA (Food and Drug Administration) guidelines, clinical recommendations published in peer review journals, and manufacturer packaging and labeling instructions. Some Quantity Limits are based on the number of units per dispensing while others are specified as a per month limit. The Pharmacy and Therapeutics Committee or the Pharmacy Benefits Administrator will review and modify this list periodically as new information becomes available.

Specialty Medications are complex and commonly high-priced medications that usually have a limited therapeutic range and are prescribed to a narrow population. Medications include injectable, infused, inhaled, or oral products, and require extensive management by a team of health care professionals provided through Prescription Solutions/Optum Rx's preferred specialty product vendors.

Specialty Pharmacy is a pharmacy that dispenses Specialty Medications, offering customized delivery, care coordination, and extensive education/counseling.

PROGRAMS

Generic Rx is a program that allows members to receive a Generic Product for a zero Copay in select therapy classes. (For an up-to-date listing of the classes, please contact Prescription Solutions/Optum Rx customer service department or visit the web site.) Covered Persons are encouraged to discuss alternative Generic Products in the classes included in the program with their Physician in order to take advantage of receiving the Generic Product for a zero Copay. This program has no effect on Plan Deductibles.

Half Tab Rx (Tablet Splitting) is a program for a defined list of Medications. When a Prescription is written for a Medication in a tablet splitting program, and the prescribed directions for use allow the Covered Person to obtain the prescribed dose by using one-half tablet, Prescription Solutions/Optum Rx will reduce the Covered Person's fixed dollar Copay by one-half. If the Covered Person's Copay is based on a percentage, the overall cost in which the percentage Copay is calculated from is split in half. Copay reductions will be applied only to Medications defined for inclusion in the tablet-splitting program.

Specialty Pharmacy Program means a program determined by the Pharmacy Benefits Administrator to require reimbursement for Specialty Medications only through the approved Specialty Pharmacy vendor(s). This reimbursement is at the Specialty Pharmacy Program level of benefits as indicated in the Prescription Benefits Summary within the Schedule of Benefits. It applies to medications the Pharmacy and Therapeutics Committee has defined as part of the Specialty Pharmacy Program. The Pharmacy and Therapeutics Committee or Pharmacy Benefits Administrator reviews and modifies the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

Step Therapy Program is a program where the Covered Person must try one or more prerequisite Medicines before the Step Therapy Medicine will be covered under the Plan. Under the Step Therapy Program, benefit levels for certain Medications identified by the Pharmacy and Therapeutics Committee will be adjusted on an individual basis. Prescribed Medications may be paid at a Preferred Product level for those individuals who meet program criteria. Currently, the program(s) available under Step Therapy include:

Leukotriene Receptor Antagonists
COX-2 Inhibitors

The Pharmacy and Therapeutics Committee or Pharmacy Benefits Administrator will review and modify this program periodically as new information becomes available.

BENEFITS

The Plan will pay for Covered Expenses incurred by a Covered Person for the purchase of prescription products. Expenses Incurred must be for the treatment of an Illness or Injury. The Plan will pay for the benefits described below minus the prescription Participation amount and/or Copay as shown in the Schedule of Benefits. The prescription Participation amount and/or pharmacy Copay cannot be used to satisfy the Health Plan Deductible amount or Health Plan Out-of-Pocket Expense Maximum.

Benefits will not be paid for Prescription products purchased before coverage with this Plan begins or after coverage under this Plan or this provision terminates.

OUT-OF-POCKET MAXIMUMS

Annual Out-of-Pocket Maximums are shown on the Schedule of Benefits. After an individual or family has met their respective Out-of-Pocket Maximums during a calendar year, the Plan will pay the remaining Covered Expenses incurred during the rest of that year, subject to the maximum fee schedule, negotiated rates agreed to, or the Usual and Customary amount.

COVERED BENEFITS

- **Prescription products which are:**
 - Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed Medical Professional; and
 - Can be obtained only by Prescription and are dispensed in a container labeled "Rx only"; and
 - The following Non-Prescription products prescribed by a duly licensed Medical Professional:
 - Compounded Medications of which at least one ingredient is a Prescription drug;
 - Any other Medications which due to state law may only be dispensed when prescribed by a duly licensed Medical Professional; and
 - Non-Prescription (or over-the-counter) products determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription; and
 - In an amount not to exceed the day's supply outlined in the Prescription Benefits Summary.
- **Preventive Care Drugs.**
- **Injectable insulin and the following diabetic supplies** with a written prescription:
 - Syringes and insulin pens;
 - Blood glucose monitors (excluding attachments);
 - Blood and urine test strips and tablets;
 - Lancets and alcohol swabs; and
 - Reaction treating products.
- **Non-combination Prescription** requiring products containing vitamins A, D, E, or K.
- **Prescription prenatal vitamins.**
- **Prescription oral contraceptives and contraceptive devices.**
- **Oral medications for cosmetic management of onychomycosis.**
- **Prescription Drugs lost as a direct result of a natural disaster.** You will be given the opportunity to prove that Medically Necessary Prescriptions were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (i.e., homeowner's, property, etc.).

- **Mail Order Prescriptions**

The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the Mail Order pharmacy identified by the Pharmacy Benefit Administrator. Prescription products may be ordered by mail with a Copay from the Covered Person for each Prescription or refill. The Copay is shown on the Prescription Benefits Summary. By law, Prescription products cannot be mailed to a Covered Person outside the United States.

- **Specialty Pharmacy Program**

The Plan pays for covered expenses incurred by a Covered Person through the Specialty Pharmacy vendor(s) identified by the Pharmacy Benefits Administrator. Prescription products included in the Specialty Pharmacy Program shall be ordered from the Specialty Pharmacy vendor(s) with a Copay from the Covered Person for each Prescription or refill. The Copay is shown on the Prescription Benefits Summary.

PRESCRIPTION PRODUCT EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Charges which are in excess of the contracted amount.
- Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments, and other non-medical substances, without regard to their intended use.
- Immunization agents, biological sera, blood, or blood plasma.
- Products labeled: "Caution-limited by federal law to Investigational use", or Experimental drugs even though a charge is made to the Covered Person. Approved Prescription products which are prescribed for Experimental or Investigational purposes or in Experimental or Investigational dosages.
- Any charge for the administration of Prescription products or injectable insulin.
- Any Medication, Prescription or Non-Prescription, which is taken or administered at the place where it is dispensed.
- Any Medication which is meant to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is treated at a Hospital, a Physician's office, or Extended Care Facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Pharmacy Benefits Administrator.
- Refilling a Prescription in excess of the number specified on the Prescription or any refill dispensed after one year from the order of the Medical Professional.
- Prescription products which are not dispensed by a licensed pharmacist or Medical Professional.
- Prescription products dispensed in a foreign country if You traveled solely for the purpose of re-importing Prescription Drugs into the United States and/or You used other means to ship or bring Prescription products from a foreign country into the United States.
- Prescriptions that are cosmetic in nature, unless the Prescription is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal Injury resulting from an Accident or trauma, or disfiguring disease.
- Prescription products which may be received without charge under local, state, or federal programs, including worker's compensation.
- Replacement Prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.
- Rogaine or any other cosmetic hair growth Prescription products.
- Prescription products, if a prior authorization was needed but not requested, and Prescription products, if prior authorization was requested but denied.
- All illegal Medications or supplies, even if prescribed by a duly licensed Medical Professional.
- Prescription products available over-the-counter that do not require a Prescription order or refill by federal or state law and any Medication that is equivalent to an over-the-counter Medication, with the exception of those Preventive Care Drugs that are required by federal law.

- Prescription smoking deterrent products.
- Anorectics or any other products used for the purpose of weight control, unless determined Medically Necessary by the Plan.
- Legend topical acne products or any other vitamin A Derivative for a Covered Person who is over age 26, unless determined Medically Necessary by the Plan.
- Approved Prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.
- Prescription products used to enhance sexual function or satisfaction, unless determined Medically Necessary by the Plan.
- Infertility products, unless used to sustain a Covered Person's pregnancy or determined Medically Necessary by the Plan.
- Growth hormone products, unless determined Medically Necessary by the Plan.
- The difference in cost between a Generic product and Brand Product when the Medical Professional has not specified a Brand Product or has not indicated that the Brand is necessary.
- Prescriptions and prescription refills that exceed our Quantity Limits.

If Your requested Medication or supply is not covered, in whole or in part, You still have a right to purchase that product. However, the entire cost of the product will be Your responsibility.

REVIEW OF MEDICATIONS AND SUPPLIES BY THE PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee may, in its professional judgment, modify Medications and supplies on the Preferred Products List as follows:

- Place products on the Preferred Products List and remove products from the Preferred Products List.
- Place certain products on the Prior Authorization List and remove products from the Prior Authorization List.
- Place certain categories of products on a Step Therapy Program and remove products from the Step Therapy Program.
- Categorize certain Non-Prescription Products (over-the-counter products) as a Covered Expense.
- Place Medications into the Specialty Pharmacy Program and remove Medications from the Specialty Pharmacy Program.

Actions by the Pharmacy and Therapeutics Committee take place quarterly as medical technology evolves and as indications or FDA (Food and Drug Administration) guidelines change.

The Pharmacy Benefits Administrator will inform You of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when Your benefits are affected.

COORDINATION OF BENEFITS

If a Covered Person has benefits through more than one Prescription Drug program, the Covered Person should pay the required Copay for the primary plan and submit the Copay due on a paper claim form to Prescription Solutions/Optum Rx. This Plan sponsor, as secondary coverage, will waive the required Copay and pay the balance due.

APPEAL PROCEDURES

Refer to the Claims and Appeal section of this document for additional details.

FOR MORE INFORMATION ON PRESCRIPTION BENEFITS

If You need more information about Your prescription benefits, please call the Pharmacy Benefits Administrator at 877-559-2955, seven days per week, 24 hours per day, or go to the web site at www.prescriptionsolutions.com.

MENTAL HEALTH PROVISION

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of mental illness, subject to any Deductibles, Copays, and Participation amounts shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule, or the negotiated rate.

COVERED BENEFITS

Covered Expenses are:

- (A) **Inpatient Services:** Subject to the following provisions:
 - (1) The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), another recognized accrediting body, or be licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility, or a qualified treatment facility for the treatment of Mental Health Disorders.
 - (2) The Covered Person must have the ability to accept treatment.
 - (3) The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment, and without such Inpatient treatment, the Covered Person's condition would deteriorate.
 - (4) The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.
 - (5) The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).
 - (6) The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified.
- (B) **Partial Hospitalization** means a treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment.
- (C) **Outpatient Services:** Subject to all the following provisions:
 - (1) Be in person in a professional, therapeutic environment; and
 - (2) Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued certification may be denied when positive response to treatment is not evident; and
 - (3) Must be provided by:
 - (a) A United States board eligible or board certified psychiatrist in the state where the treatment is provided;

- (b) A therapist with a Ph.D or Master's degree that denotes a specialty in psychiatry;
- (c) A state licensed psychologist;
- (d) A state licensed or certified Social Worker with a Master's degree, or a Social Worker with a Bachelor of Science degree who is under the supervision of a psychiatrist or psychologist; or
- (e) Licensed Practical Clinician.

ADDITIONAL PROVISION

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history, initial assessment, and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued certification will be denied.

MENTAL HEALTH EXCLUSIONS (In addition to the General Exclusions discussed later):

The Plan will not pay for:

- Treatment or care that is not considered Medically Necessary or appropriate, as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a Covered Benefit elsewhere in this document.
- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.
- Stress Management.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY PROVISION

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Copays, Participation amounts, maximum, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary charge, or the negotiated rate as applicable.

COVERED BENEFITS

Covered Expenses are:

- (A) **Inpatient Services:** Subject to the following provisions:
 - (1) The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), another recognized accrediting body, or be licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility, or a qualified treatment facility for the treatment of substance abuse and chemical dependency.
 - (2) The Covered Person must have the ability to accept treatment.
 - (3) The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment, and without such Inpatient treatment, the Covered Person's condition would deteriorate.
 - (4) The Covered Person's condition must be treatable in an Inpatient facility.
 - (5) The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).
- (B) **Partial Hospitalization** means a treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.
- (C) **Outpatient Services:** Subject to the following provisions:
 - (1) Be in person in a professional, therapeutic environment; and
 - (2) Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued certification may be denied when positive response to treatment is not evident; and
 - (3) Must be provided by:
 - (a) A United States board eligible or board certified psychiatrist in the state where the treatment is provided;
 - (b) A therapist with a Ph.D or Master's degree that denotes a specialty in psychiatry;
 - (c) A state licensed psychologist; or
 - (d) A certified addiction counselor.

ADDITIONAL PROVISION:

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history, initial assessment, and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued certification will be denied.

SUBSTANCE ABUSE EXCLUSIONS (In addition to the General Exclusions in this document):

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Inpatient treatment for intoxication without evidence or history of medical complications.

HEARING AID BENEFITS

This Plan includes a benefit that will allow Covered Persons who are age 18 and older to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC on its toll free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct them to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services out-of-pocket prior to the delivery of services.

Because this Plan does not have additional hearing aid benefits for Covered Persons who are age 18 and older, Covered Persons who are age 18 and older should not submit a claim for reimbursement to the Plan for EPIC products or services. Covered Persons who utilize the EPIC discounts should communicate directly with EPIC to obtain the discount. In the event that a Covered Person who is age 18 or older submits a claim for reimbursement, the claim will be denied because the Plan does not provide additional coverage beyond the EPIC discounts for these products and services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, You should contact EPIC directly at their toll free number 1-866-956-5400 or write to them at: EPIC Hearing Services, 17870 Castleton Street, Suite 320, City of Industry, CA 91748.

UTILIZATION MANAGEMENT And Other Medical Management Services

The Utilization Review Organization is: **Medical Management Department of Arise Administrators (henceforth "Medical Management Department")**.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Certification at least three weeks prior to the scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Certification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis should contact the Medical Management Department as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Medical Management Department will then review services provided within 48 hours of notification.

DEFINITIONS

Utilization Management means a formal assessment of the Medical Necessity, effectiveness, and appropriateness of health care services and treatment plans and an assessment of the Facility in which the treatment is being provided. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

Certified or Certification for the purpose of Hospital admission for giving birth means notification to the Medical Management Department of the upcoming need for medical treatment and where services will be provided. For all other purposes, Certification means a determination by the Medical Management Department, on behalf of the Plan, with respect to whether a service, treatment, supply, or facility is Medically Necessary for the care and treatment of an Illness or Injury.

Notified or Notification means the Medical Management Department, on behalf of the Plan, is contacted and made aware of necessary and expected impending medical care.

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed, primarily established, and operating within the scope of its license.

If You are to be admitted to a qualified treatment facility, You or Your qualified practitioner must contact the Medical Management Department by telephone (**920-617-6363 local or 1-888-833-4988 toll free**) or in writing at least 7 days before Your admission. If necessary, the Medical Management Department may certify Your admission by telephone on 24 hours notice. The Medical Management Department will:

1. Review Your qualified practitioner's treatment plan;
2. Advise You and Your qualified practitioner if the proposed confinement is certified as Medically Necessary; and
3. Advise You how many days the confinement is certified.

If You are admitted on an emergency basis, You or Your qualified practitioner must contact the Medical Management Department within 24 hours or the first business day following Your admission to obtain certification of Your confinement. The Medical Management Department will review the same information as mentioned in the previous paragraphs when You are admitted on an emergency basis.

SERVICES REQUIRING CERTIFICATION

Call the Medical Management Department **before** You receive services for the following:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.
- All Inpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse, and chemical dependency.
- Inpatient stay in a Hospital or Birthing Center for the purpose of giving birth.

Note that if a Covered Person receives Certification for one facility, but then the person is transferred to another facility, Certification is also needed before going to the new facility.

PENALTY FOR NOT OBTAINING CERTIFICATION:

A non-notification penalty is the amount You must pay if You do not call for certification prior to receiving certain services. A penalty does not apply towards the Deductible or out-of-pocket maximum. A penalty of 20% to a maximum out-of-pocket of \$100 will be applied per admission if a Covered Person receives services but did not obtain the required certification.

Special Notes:

This Plan complies with the Newborns and Mothers Health Protection Act. The Certification requirement is not required to certify Medical Necessity for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Certification is required to use certain providers or facilities, or to reduce Your out-of-pocket costs.

The phone number that You should call for Certification is listed on the back of Your identification card.

Even though a Covered Person receives Certification from the Medical Management Department that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this document.

EXTENSION OF A CERTIFIED ADMISSION

If Your doctor extends Your confinement beyond the number of days certified, the Medical Management Department must certify the extension.

IF THE EXTENSION IS NOT CERTIFIED, BENEFITS FOR THE EXTENSION WILL BE PAYABLE AS DESCRIBED UNDER "PENALTY FOR NOT OBTAINING CERTIFICATION."

Other Medical Management Services

The **Disease Management program** utilizes multiple identification and stratification methods to identify individuals who have certain chronic diseases and would benefit from this program. Prevea Health administers the Disease Management program on behalf of the Plan. Prevea Health's nurse case managers actively work with Covered Persons to help them improve their chronic disease and maintain quality of life.

Services are provided over the telephone, in person, or through the mail. The Disease Management program utilizes an Opt-Out approach. The Opt-Out approach means that if a Covered Person is identified with one of the chronic diseases, the Covered Person will receive information in the mail or be contacted by Prevea Health, unless the Covered Person declines participation in this program through a written statement to the Plan.

Our Disease Management program includes the issuance of Personal Care Calls (PCCs) to identified members. PCCs are generated based on a review of medical and Prescription claim data for all members eligible for the Disease Management program. Prevea Health identifies and targets those members who are not receiving certain clinically appropriate services or who could save money related to Prescription drug use by switching to less costly therapeutically equivalent drugs. The PCC will highlight their recent claim history and care gaps, as well as provide them with suggestions on ways to improve their health and reduce their out-of-pocket costs.

Case Management services is a planned approach aimed at promoting more effective treatment for patients with serious medical problems. Arise Administrators' Case Management Specialists communicate directly with the patient's attending Physician to address the specific medical or psychological needs of the patient, and to mobilize appropriate resources for patient care. Our philosophy is that quality care from the beginning of a serious illness helps avoid major complications in the future. The Covered Person can request that the Plan provide case management services, or in some cases, the Plan may contact You if the Plan believes case management services may be beneficial.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not, however, apply to Prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The Order of Benefit Determination Rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies. See Order of Benefit Determination Rules.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no Coordination of Benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – No-Fault State in this SPD for more details.
- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.
- The plan that covers a person as a Dependent (or beneficiary under ERISA) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- If one or more plans cover the same person as a Dependent child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.
 - If the parents are not married and reside separately or are divorced or legally separated, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive Employee: If an individual is covered under one plan as an active Employee (or dependent of an active Employee) and is also covered under another plan as a retired or laid off Employee (or dependent of a retired or laid off Employee), the plan that covers the person as an active Employee (or dependent of an active Employee) will be primary.
- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. (See exception in the Medicare section.)
- Longer or Shorter Length of Coverage: The plan that covered the person as an Employee, member, subscriber, or retiree longer is primary.
- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The Order of Benefit Determination Rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:
 - You continue to be actively employed by the employer, and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
 - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first (has primary responsibility) under the following circumstances:
 - You are no longer actively employed by an employer; and
 - You or Your spouse has Medicare coverage due to Your age, plus You also have COBRA continuation coverage through the Plan; or
 - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first. However, an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
 - You or Your covered spouse have coverage under a retiree plan plus Medicare coverage; or
 - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid, the person for whom the Plan has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT, THIRD PARTY LIABILITY AND ASSIGNMENT OF RIGHTS PROVISION

This provision arises when a Covered Person has received benefits under this Plan and has also received payments from any other responsible party for the same Illness or Injury.

The Plan's Rights:

When a Covered Person receives a benefit from this Plan for an Illness or Injury, and the person is entitled to recover payment from any party who may be obligated to pay for such Illness or Injury, then the Plan is Subrogated to all rights to recover:

- Any payments which the Covered Person or any other person or organization on behalf of the Covered Person is entitled to as a result of such Illness or Injury, to the extent this Plan paid or provided a benefit; and
- Any overpayments made directly to providers on behalf of the Covered Person for the Illness or Injury.

The Plan's right to full recovery may be from a third party, any liability or other insurance covering a third party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments insurance, no-fault insurance, or school insurance coverage that are paid or payable.

The Plan's right to subrogate or be reimbursed shall not apply unless the Covered Person has been made whole for the loss.

The Plan will not pay fees or costs associated with any claim/lawsuit without the Plan's express written consent in advance. The Plan reserves the right to independently pursue and recover paid benefits.

The Plan's subrogation and reimbursement rights apply to the Covered Person, to the spouse and Dependents of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.

Your Responsibilities:

The Covered Person or other persons receiving such payments from the Plan for the Illness or Injury shall:

- (A) Sign and deliver all necessary papers that will enable this Plan to recover payments made by another party; and
- (B) Do whatever else is necessary to protect this Plan's rights; and
- (C) Not do anything that would prejudice this Plan's right to recover payments; and
- (D) Obtain the Plan's approval before you agree to settle a claim for recovery or reimbursement for the Injury or Illness; and
- (E) Notify the Plan within 30 days of the incident if third-party liability occurs.

GENERAL EXCLUSIONS

Exclusions are items that are not considered benefits under this Plan. However, **complications** from these procedures will be considered for payment in accordance with Plan provisions.

The Plan does not pay for expenses incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section when the Plan has information that the Illness or Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that:
 - The mother's life would be in danger if the fetus were to be carried to term; or
 - Abortion is medically indicated due to complications with the pregnancy.
2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment** except for anesthesia or pain control.
4. **Alternative Treatment:** Treatment, services, or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy.**
7. **Assistance with Activities of Daily Living.**
8. **Assistant Surgeon Services,** unless determined Medically Necessary by the Plan.
9. **Augmentation Communication Devices** and related instruction or therapy.
10. **Before and After Termination:** Services, supplies, or treatment rendered before coverage begins under this Plan or after coverage ends are not covered.
11. **Blood:** Blood donor expenses.
12. **Cardiac Rehabilitation** beyond Phase II.
13. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate, and not Experimental or Investigational for the medical condition for which the treatment is recognized.
14. **Close Relative:** Services performed by a Close Relative or by someone who ordinarily lives in the Covered Person's home.
15. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless for reconstructive surgery due to a bodily Injury, infection, or other disease of the involved part.
16. **Counseling Services** in connection with marriage, pastoral, or financial counseling.
17. **Court-Ordered:** Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered

by this Plan. This Plan does not cover the cost of Driving While Intoxicated classes or other classes ordered by the court.

18. **Custodial Care.**
19. **Dental:** The care and treatment of teeth, gums, or alveolar process; for dentures, appliances, or supplies used in such care or treatment; or Drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for X-ray, lab, and anesthesia, for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident. This exclusion also does not apply to dentures as a result of extraction and initial replacement of natural teeth.
20. **Dental:** Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
21. **Dental Implants** including preparation for implants.
22. **Disorders:** Services in connection with learning disabilities or Developmental Disorder. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
23. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.
24. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care.
25. **Employment or Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment, including self-employment, whether or not for wage or profit.
26. **Environmental Devices:** Environmental items, including but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
27. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes; sports or recreational activity; or premarital tests or examinations.
28. **Expenses** incurred for which you are entitled to receive benefits during any extension period of your previous medical plan.
29. **Experimental or Investigational:** Services, supplies, medicines, treatment, facilities, or equipment which the Plan determines are Experimental or Investigational.
30. **Extended Care:** Any Extended Care Facility services which exceed the appropriate level of skill required for treatment as determined by the Plan.
31. **Eye** refraction, eyeglasses, or the fitting or repair of eyeglasses.
32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or body building.
33. **Foot Care:** Routine foot care and removal of corns, calluses, toenails, or subcutaneous tissue, except when care is prescribed by a Physician treating metabolic or peripheral vascular disease.
34. **Genetic Counseling,** studies, testing, or surgery based only on a family history of having a disease, rather than on Medical Necessity for an existing medical problem, with the exception of

genetic counseling and evaluation for BRCA testing for those women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes.

35. **Habilitative Services** including vocational or industrial rehabilitation services or work hardening.
36. **Hearing Devices:** The purchase or fitting of hearing aids for Covered Persons who are age 18 or older or Soundtec implants.
37. **Home Modifications:** Modifications to Your home or property, including but not limited to, escalators, elevators, saunas, steambaths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.
38. **Hypnotism:** Hypnotism and biofeedback.
39. **Infertility Treatment** and direct attempts to achieve pregnancy by any means. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
40. **Lamaze Classes** or other child birth classes.
41. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or clinical evidence indicates that a plateau has been reached in terms of improvement from such services.
42. **Military:** A military related illness or injury to a Covered Person on active military duty.
43. **Nicotine:** Services, treatment, or supplies related to addiction to or dependency on nicotine.
44. **No-Fault State:** Benefits are not payable under this Plan for any illness or injury received in an accident involving a car or other major vehicle for participants who are residents of a No-Fault state and are eligible for benefits under the No-Fault motor vehicle law, until such time as the benefits under No-Fault have been exhausted.
45. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards.
46. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary, are furnished while you are not under regular care of a qualified practitioner, or are not authorized or prescribed by a qualified practitioner.
47. **Orthopedic Items:** Charges for shoe orthotics, orthopedic shoes, arch-supports, or exam for the prescription or fitting thereof, unless covered elsewhere in this Plan.
48. **Over-The-Counter Medication,** products, or supplies.
49. **Penalties.**
50. **Personal Comfort:** Services or supplies for personal comfort or convenience, including but not limited to, private room, television, telephone, and guest trays.
51. **Prescription Medication,** other than those administered while in the Hospital or Physician's office as part of treatment, unless benefits are provided under the Prescription Benefit provision of this Plan.
52. **Prescription Medication:** Take home drugs filled by a Hospital or Physician's office, unless benefits are provided elsewhere in this Plan.

53. **Private Duty Nursing Services.**
54. **Repairs:** Maintenance or repair of Durable Medical Equipment due to abuse or misuse of equipment.
55. **Return to Work/School:** Telephone consultations or completion of claim forms or forms necessary for the return to work or school.
56. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
57. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgery Center.
58. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.
59. **Services at No Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code or as required by law.
60. **Services** and supplies furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
61. **Services Not Medically Necessary** for diagnosis and treatment of bodily injury or sickness.
62. **Services Provided by a Close Relative.** See Glossary of Terms for the definition of Close Relative.
63. **Sex Therapy.**
64. **Sexual Function:** Any medications, oral or other, used to increase sexual function or satisfaction, unless due to a medical condition.
65. **Sex Transformation:** Treatment, drugs, medicines, services, and supplies for, or leading to, sex transformation surgery.
66. **Supplements:** All enteral feedings, supplemental feedings, over-the-counter nutritional, and electrolyte supplements and products.
67. **Surrogate Motherhood** expenses.
68. **Taxes:** Charges for federal, state, and local taxes unless required by law.
69. **Telemedicine.**
70. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
71. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan. This exclusion does not apply to travel immunizations or travel counseling covered under the Preventive Care benefits.
72. **Usual and Customary Charges:** Charges, or the portion thereof, that are in excess of the Usual and Customary charge or the negotiated fee.

73. **Visual Acuity:** Refractive errors by any means.
74. **Vitamins, Minerals, and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections and pre-natal vitamins that are prescribed by a Physician for Medically Necessary purposes.
75. **Vocational Testing, Evaluation, and Counseling:** Vocational and educational services rendered primarily for training or education purposes.
76. **Warning Devices:** Warning devices or other types of apparatus used for diagnosis or monitoring.
77. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness. This does not include services for Morbid Obesity as listed in the Covered Medical Benefits section of this document.
78. **Wigs, Toupees, Hairpieces**, hair implants or transplants, hair weaving, or any similar item for replacement of hair regardless of the cause of hair loss.
79. Any loss caused or contributed to by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict, or any conflict involving armed forces or any international authority;
 - Atomic or nuclear explosion or resulting radiation; or
 - Participation in a riot.
80. Any medical expense due to criminal battery or felony upon conviction of said offense.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is a Non-Participating Provider, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Participation level, with the Covered Person being responsible for a larger percentage of the total medical expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. Arise Administrators will normally send payment for Covered Expenses directly to the Covered Person's provider.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing certification as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan **before** obtaining the medical care such as in the case of certification of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this document specifically require the person to call for certification. Obtaining certification does not guarantee that the Plan will ultimately pay the claim.

Note that this Plan does not require certification for urgent or Emergency care claims.

However, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if it could seriously jeopardize the person's life, health, or ability to regain maximum function, or if in the opinion of a Physician who has knowledge of the person's medical condition, it would subject the person to severe pain that could not be adequately managed without the treatment or care being requested.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

AUTHORIZED REPRESENTATIVE

Authorized Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as an Authorized Representative.

If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: the name of the Authorized Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant their Authorized Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines discussed below. The address for submitting medical claims is on the back of the group health identification card.

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the Prescription Drug identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should contact the number on the back of the Prescription Drug identification card for further instructions on how to proceed.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the Provider is paid. If the Provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim or on the date of service if the paid date is not known.

PROOF OF LOSS

Covered Persons are responsible for ensuring that complete claims are submitted to the Claim Administrator as soon as possible after services are received, but no later than 15 months from the date of service. Prescription benefit claims must be submitted within 15 months from the date of service. Covered Persons can request a Prescription claim form by writing Prescription Solutions/Optum Rx at PO Box 8082, Wausau, WI 54402-8082 or by calling the number on the back of the Prescription Drug identification card. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Authorized Representative does not properly follow the Plan's procedures for requesting certification, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Authorized Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When Arise Administrators receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, Arise Administrators will establish the allowable payment amount for that service in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a negotiated rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Copay, or penalties that the Covered Person is responsible for paying.

Negotiated Rate: On occasion, Arise Administrators will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The negotiated rate is what the Plan will pay to the provider, minus any Copay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment, or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. The U&C guidelines do not apply to In-network claims, which are governed by the network contract. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is

customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

Note: For Prescription benefits, Covered Persons will receive an EOB when a Covered Person files a claim directly with Prescription Solutions/Optum Rx. Benefits received or denied at the point of sale in the Pharmacy are not considered claims. See Procedures For Submitting Claims for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Arise Administrators will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- **Pre-Service Claim:** A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may take an extra 15 days when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- **Post-Service Claims:** Claims will be processed within 30 calendar days, but the Plan may take an additional 15 days when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- **Concurrent Care Claims:** If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment authorization ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to Arise Administrators for formal consideration under the terms of this Plan.

Determination Period On Hold: The time period that the Plan has to decide a claim may be put on hold ("tolled") when additional information is necessary from the Covered Person to process the claim. When claims information is missing, a notice requesting the necessary information will be sent to the Covered Person. The Covered Person then has 60 calendar days within which to provide the missing information.

If the Covered Person does not provide needed information to the Plan within 60 calendar days of the date on the notice, the Plan will make a decision on the claim based upon the information it has at that time, which may result in a denial or partial denial. The Covered Person will be fully responsible for payment of expenses not covered because of a denied or partially denied claim.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.

- Termination of the group health Plan.
- Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to have required services certified before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, penalties, or Copays.
- Application of the Usual and Customary fee limits, fee schedule, or negotiated rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in a plan.

If a claim is being denied in whole or in part, the Covered Person will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and this information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his/her Authorized Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. Please note that an appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is an Authorized Representative.

The Covered Person can make this request by submitting a written letter, including all applicable documentation to explain why the Covered Person thinks the claim should be paid, to the Plan **within 60 calendar days** after receiving a written claims denial from the Plan. The Plan will assume that the Covered Person received the written notice of claims denial three days after the Plan mailed the notice to the Covered Person. The Covered Person or his/her authorized representative will be allowed to review pertinent documents and submit issues and comments in writing. One additional extension of 60 days is possible if special circumstances exist. However, if this extension is needed, the Covered Person must

give the Plan written notice that the Covered Person needs the extension. This notice must be sent to the Plan within the initial 60-day period. The address for submitting appeals is listed on the explanation of benefits.

When reviewing a claim that has been appealed, the Plan will consider any and all pertinent information reasonably available, including new medical evidence that was not available or utilized when the original benefit determination was made. Relevant experts may be retained and considered, if appropriate. The Plan has 60 days to make a decision on the review. An extension of another 60 days is available if the Plan provides the Covered Person with written notice that an extension is needed. The Covered Person will receive a written notice of the Plan's determination within allowable timelines.

Appeals should be sent within the prescribed time period as stated above to:

ARISE ADMINISTRATORS
APPEALS COORDINATOR
PO BOX 11625
GREEN BAY WI 54307-1625

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines:

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the employer determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

Covered Persons must:

- File accurate claims. If someone else - such as the Covered Person's spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it; and
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on the Covered Person's knowledge of the expenses Incurred and the services rendered; and
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call 920-617-6363 local or 1-888-833-4988 toll free. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT

If an Employee is on an approved family or approved medical leave of absence under the State or Federal Family Medical Leave Act, Your employer may continue coverage under this Plan in accordance with the requirements of the Act as if the Employee was Actively at Work if the following conditions are met:

- (A) Contribution is paid; and
- (B) The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- (A) The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
- (B) The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the Employee becomes Actively at Work:

- (A) No new Waiting Period will apply; and
- (B) Pre-Existing Condition Exclusions shall not apply.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- (A) The name and last known mailing address of the participant; and
- (B) The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient); and
- (C) A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined.

Please contact the Plan Administrator if You would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

FEDERAL BENEFIT REGULATIONS

This group health plan also complies with the provisions of the:

- Health Insurance Portability and Accountability Act (HIPAA) regarding the health insurance portability provisions.
- Newborn & Mothers Health Protection Act.
- Children's Health Insurance Reauthorization Act of 2009.

- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby employers will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Michelle's Law, whereby coverage is continued for up to one year for students who take a Medically Necessary leave of absence from an institution of higher learning.
- Mental Health Parity and Addiction Equity Act of 2008.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely. However, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Plan participants within 60 days following the adopted formal action that makes material changes to the Plan.

Your Rights if Plan is Amended or Terminated:

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses incurred before You receive notice of termination.

The Plan will assume that You received the written amendment or termination letter from the Plan Administrator three days after the letter is mailed to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

No Contract of Employment

This Plan is not intended to be and may not be construed as a contract of employment between You and the employer.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use Your Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose Your PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose Your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share Your PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan shall Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose Your PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of Your PHI:

- The Plan Sponsor will only Use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law, or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;
- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books, and records relating to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources Director, Benefits Analyst, Benefits Clerk, Mayor, Information Technology Director, City Attorney, Deputy City Attorney, Assistant City Attorney, Finance Director, Water Utility Manager

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive Your PHI. If any of these Employees or workforce members Use or Disclose Your PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to You.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Claim Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information, collected from a Covered Person and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract, and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing, and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen, and unintended event.

Accredited Institution of Higher Education means, for purposes of this Plan, a two-year or four-year college or university, or licensed trade school.

Actively at Work means continuous employment at the employer's normal place of business (or at some other location to which the employer's business requires You to travel) during the employer's normal work week. Normal work week and benefits are determined by employment contract.

Activities Of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting and associated personal hygiene, transferring (which is to move in and out of a bed, chair, wheelchair, tub, or shower), mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Ambulance Transportation means professional ground or air Ambulance Transportation in an emergency situation or when deemed Medically Necessary that is:

- (A) To the closest facility most able to provide the specialized treatment required; and
- (B) The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery, and postpartum care to the pregnant individual and newborn child under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Claim Administrator is a health claim administrator hired by the Plan to process medical claims, provide medical management or perform other administrative services. The Claim Administrator does not assume liability for payment of benefits under this Plan.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, step children, and grandchildren.

Copay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any charge, or portion thereof, which is Incurred as a result of receiving a Covered Benefit under this Plan.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Creditable Coverage means coverage an individual has under the following, as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);

- Medicare;
- Medicaid, including BadgerCare Plus;
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A State health benefits risk pool;
- Children's Health Insurance Program (CHIP);
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a State, the US government, a foreign country, or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits, and other excepted benefits as defined by federal law and applicable regulations.

Custodial Care means nonmedical care given to a Covered Person to assist primarily with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible and the health care benefits to which it applies.

Dependent - see Eligibility and Enrollment section of this SPD.

Developmental Disorder is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior, and communication skills. Developmental Disorders generally do not have a history of birth trauma or other illness that could be causing the impairment such as a hearing problem, mental illness, or other neurological symptoms.

Durable Medical Equipment is equipment which is designed for repeated use, is intended to treat or stabilize a Covered Person's illness or injury or improve function, and generally is not useful to a person in the absence of an illness or injury.

Emergency means a serious medical condition which arises suddenly and requires immediate care and treatment.

Enrollment Date means:

- (A) For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.
- (B) For anyone who enrolls on a Special Enrollment date, the Enrollment Date is the first day of coverage.
- (C) For Late Enrollees, the Enrollment Date is the first day of coverage.

Expense Incurred means the charge for a service, treatment, supply, or facility. The expense is considered to be incurred on the date the service or treatment is given, the supply is received, or the facility is used.

Experimental or Investigational means any supply, medicine, facility, equipment, service, or treatment that:

- (A) Is not currently or at the time the charges were incurred recognized as acceptable medical practice by the Plan. (FDA approval does not necessarily constitute accepted medical practice.)
- (B) Is subject of or related to ongoing Phase I, II, or III clinical trials. (A drug, device, procedure, service, or treatment will not be considered Experimental or Investigational if it is the subject of ongoing Phase III clinical trials and the Covered Person meets the Phase III protocol requirements to participate as determined by the Plan.)
- (C) Requires the Covered Person to sign a release or other document indicating that the treatment is Experimental or Investigational or other similar terms.
- (D) Has not been approved by the appropriate government regulatory bodies.
- (E) A drug, device, procedure, service, or treatment must have Food and Drug Administration (FDA) approval for those specific indications and methods of use for which such drug, device, procedure, service, or treatment is sought to be provided, subject to medical judgment by Arise Administrators' medical staff or qualified outside medical reviewers.

Any drug, device, procedure, service, or treatment, which at the time sought to be provided is not approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare, is considered an Experimental procedure.

Drugs are considered Experimental if they are not commercially available for purchase and are not approved by the FDA for general use. General use refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process are considered Experimental procedures.

Any drug or test approved by the FDA for a specific disease, Injury, Illness, or condition, but which is sought to be provided for another disease, Injury, Illness, or condition, is considered Experimental, subject to medical judgment by Arise Administrators' medical staff or qualified outside medical reviewers.

Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered Experimental.

- (F) Based on prevailing peer reviewed medical literature in the United States, there is failure to demonstrate that the treatment is safe and effective for the condition, and that there is not enough scientific evidence to support conclusions concerning effect of the drug, device, procedure, service, or treatment on health outcomes.

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the drug, device, procedure, service, or treatment can measure or alter the sought after changes to the disease, Injury, Illness, or condition. In addition, there must be evidence or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels, other technology evaluation bodies, or outside independent review organizations are evaluated according to the scientific quality of the supporting evidence and rationale.

References used in the evaluation include, but are not limited to, The American Cancer Society, The American Medical Association, FDA, US Department of Health & Human Services, JAMA, Apollo Review Criteria Guidelines, Merck Manual, Milliman Care Guidelines, Mosby Advanced Catalog Search, National Guideline Clearinghouse, National Library of Medicine Search, National Institutes of Health, Pubmed (Medicine), The Hayes Directory of New Medical Technologies, and/or the American Academies or Colleges of various Physician specialties.

A service, supply, treatment, or facility may be considered Experimental or Investigational, even if the provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the illness or injury.

Extended Care Facility includes, but is not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital; and is licensed by the state in which it operates and provides the services under which the licensure applies.

Habilitative Services means services which are educational in scope and purpose and are rendered to develop, improve, or accelerate functions that have never been present or are not present to the normal degree of a person of like age or sex.

Home Health Care means a formal program of care and intermittent treatment that is:

- (A) Performed in the home; and
- (B) Prescribed by a Physician; and
- (C) Intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and
- (D) Prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and
- (E) Organized, administered, and supervised by a Hospital or Qualified licensed provider under the medical direction of a Physician; and
- (F) Appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, Nurse Services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care (i.e., care that is not provided on a continuous, non-interrupted basis).

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider is an agency or organization that has Hospice Care available 24 hours a day, seven days a week, is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician, physical therapist, or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- (A) A facility that is licensed as an acute Hospital; and
- (B) Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients; and
- (C) Has a staff of licensed Physicians available at all times; and
- (D) It is accredited by the Joint Commission of Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA) and is qualified to receive payments under the Medicare program; and
- (E) Always provides 24 hour nursing services by registered graduate nurses; and
- (F) Is not a place primarily for Custodial or Maintenance Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote Fertility, achieve a condition of pregnancy, or treat an Illness causing an Infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to: Fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; and direct attempts to cause pregnancy by any means including, but not limited to, hormone therapy or drugs, artificial insemination, In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transfer, and freezing or storage of embryo, eggs, or semen.

Injury means an act causing harm or damage to the body.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on the earliest date on which coverage can become effective under the terms of this Plan or a special enrollment date for a person as defined by HIPAA.

A Late Enrollee does not include a person who:

- (A) Requests enrollment under the Plan within 60 days after loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP; or

- (B) Requests enrollment under the Plan within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP, has been determined.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Medically Necessary means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an illness or injury and which meet all of the following criteria as determined by most qualified Medical Practitioners who are licensed to diagnose or treat that bodily injury or sickness.

- (A) The health intervention is for the purpose of treating a medical condition; and
- (B) Is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- (C) Is known to be most effective and applicable in improving health outcomes. To determine if a treatment, service, or supply is effective, scientific evidence will be followed. If scientific evidence is not available, is in dispute, or is insufficient, effectiveness will be determined by utilizing the professional standards of the American Medical Association, and finally, by expert medical opinion; and
- (D) Is cost effective for this condition. Cost effective does not necessarily mean the lowest price; and
- (E) Not primarily for the convenience or preference of the Covered Person, his or her family, or any provider.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Mental Health Disorder means disorders that are clinically significant psychological syndromes associated with distress, dysfunction, or illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, illness, or death.

Mentally Disabled means an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Morbid Obesity means a Body Mass Index (BMI) that is greater than or equal to 40 kg/m², or if there are serious medical conditions that are exacerbated or caused by obesity such as severe hypertension, Pickwickian syndrome, or insulin-dependent diabetes, a BMI greater than or equal to 35 kg/m² is applied.

Ordinary Care means the degree of care, skill, and diligence that a reasonable and prudent administrator would exercise in making a fair determination on a claim for benefits similar to the claim involved.

Orthotic Appliances means braces, splints, and other appliances used to support or restrain a weak or deformed part of the body and are designed for repeated use, are intended to treat or stabilize a Covered

Person's Illness or Injury or improve function, and generally are not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Participating Pharmacy means a licensed entity, acting within the scope of their license in the state in which they dispense, that has entered into a written agreement with Prescription Solutions/Optum Rx and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Physician means any of the following licensed practitioners who perform service payable under this Plan: a doctor of medicine (MD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), or a physicians assistant (PA), a certified nurse midwife (CNM), or a nurse practitioner (NP) acting within the scope of their license in the state in which they practice and performing a service which would be payable under this Plan when performed by an MD.

Placed for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care, or treatment was recommended or received within six consecutive months prior to the Covered Person's Enrollment Date.

Preventive Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is Routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

Primary Care Physician (PCP) means a participating Physician who practices in the area of family practice, internal medicine, pediatrics, general practice, or obstetrics/gynecology.

Provider Directory means a list of the Participating Providers.

Qualified means licensed, registered, or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, Accident, or Illness. It is generally performed to achieve a normal appearance and may also be performed to improve or restore function.

Retired Employee means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

Surgical Center means a licensed facility that is: under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- (A) Provides drug services as needed for medical operations and procedures performed;

- (B) Provides for the physical and emotional well being of the patients;
- (C) Provides Emergency services; and
- (D) Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM).

Transaction means engaging in electronic communications regarding billing, payment, coordination of benefits, enrollment, and disenrollment and eligibility.

Usual and Customary applies to Non-Participating Providers and means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period means the period of time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

We, Our, Us, or The Plan means CITY OF GREEN BAY.

You, Your means the Employee.