CITY OF LA CROSSE

MEDICAL BENEFIT PLAN

MASTER PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Updated Effective January 1, 2017

IMPORTANT MESSAGE

NOTIFY THE PLAN ADMINISTRATOR (CITY OF LA CROSSE HUMAN RESOURCES) IF:

- ***You*** **get married**
- **A *child* is born, adopted or placed for adoption**
- **Your *dependent child* reaches the *dependent* age limit or no longer meets *dependent* eligibility criteria**
- ***You*** **are divorced**
- ***You*** **change your address**

To add a *dependent,* a completed enrollment form is required and must be received within thirty-one (31) calendar days of the qualifying event (or within the annual open enrollment period). Enrollments outside of these events would be considered a "late enrollee" and the effective date of coverage would be delayed.

An event causing loss of coverage (divorce, legal separation, or a *dependent* losing eligibility for coverage, etc.) must be reported in writing within 60 days of the event or *COBRA* rights may no longer be available. Refer to the Continuation of Medical Benefits Section (*COBRA*) for additional information.

IT IS YOUR RESPONSIBILITY TO ENSURE THAT THE CITY OF LA CROSSE HUMAN RESOURCES DEPARTMENT HAS UP TO DATE INFORMATION ON FILE FOR *YOU*

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SCHEDULES OF BENEFITS

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RECITALS

City of La Crosse (City), a Wisconsin municipality, hereby establishes its self-funded Medical Benefit Plan (Plan) for the benefit of eligible Employees, Retirees, and their eligible Dependents. The benefits described in this document are ***not*** conditions of employment, nor are they meant to establish a contract between City and its Employees. Neither enrollment nor anything contained in this Plan shall give any Employee the right to be retained in the employ of City nor shall it interfere with the right of City to discharge any Employee at any time.

This document constitutes the entire Plan and supersedes all the prior Plan documents. To the extent the Plan document has been changed, the intent of the change is to incorporate required new Federal Legislative changes such as those due to the Patient Protection and Affordable Care Act, HIPAA, etc. Additionally, any new Wisconsin State Statutory requirements have been incorporated. However, in the event the Federal or State of Wisconsin law requiring any plan provision shown is repealed or amended at any time, the City has the right to revert to any previous provision that is allowed by law.

The City has caused this instrument to be executed by its duly authorized officer(s) this 15 day of January, 2017 effective for healthcare services incurred on or after January 1, 2017

City of La Crosse

Attest: Wendy K Oestreich Director of Human Resources

Signature Title

CITY OF LA CROSSE MEDICAL BENEFIT
MASTER PLAN DOCUMENT

This document, which includes the Schedule of Benefits found at the end of the document, is both the Master *Plan* Document and Summary *Plan* Description for the City of La Crosse Medical Benefit *Plan* and will be provided to *employee*s and other *plan participants*. In a conflict between the Master *Plan* Document and any other written benefit summary information, the Master *Plan* Document controls. Subject to the limitations, exclusions and conditions of the Master *Plan* Document, the *plan participants* are entitled to the *Covered Services* described in this Master *Plan* Document. Except where stated otherwise, the *Plan* applies a *Deductible*, *Co-payment, Coinsurance* and a *maximum benefit* to *Usual*, *Customary* and *Reasonable charge*s for *covered services*. In *Network* charges are not subject to *Usual, Customary and Reasonable charges*. The Schedule of Benefits identifies the amount of the *Deductible*, *Co-payment*, *Coinsurance* and *Maximum benefit* which apply to *plan participants*.

PLAN DESCRIPTION INFORMATION

1. **Proper Name of Plan**: City of La Crosse Medical Benefit Plan

2. **Plan Sponsor**: City of La Crosse

3. **Plan Administrator and Named Fiduciary**: City of La Crosse
   Human Resources Department
   400 La Crosse St.
   La Crosse, Wisconsin 54601-3396
   (608)789-7595
   (608)789-7598 (Fax)

4. ***Employer* Identification Number**: 39-6005490

5. **Type of *Plan*:** self-funded medical and drug indemnity benefit plan. The *Plan* provides medical and *prescription* drug benefits for participating *employee*s, *retirees* and their enrolled *dependent*s and other participants as indicated in this document or as specified in applicable collective bargaining agreements.

   ***Plan* Status: Non-Grandfathered under healthcare reform laws.**

6. *Plan* benefits described in this booklet are effective January 1, 2017.

7. The *Plan year* and fiscal year are January 1 through December 31 of each year.

8. **Agent for service of legal process**: City of La Crosse
   Human Resources Department
   400 La Crosse St.
   La Crosse, Wisconsin 54601-3396

9. The ***Plan Supervisor*** is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Supervisor* for the Health Traditions (Franciscan Skemp) *Network* is:

   Custom Benefit Administrators (CBA)
   305 5th Avenue, Suite 206
   La Crosse, WI 54601
   (800)944-2188 or (608)784-2442
   Fax (608)785-0063

The ***Plan Supervisor*** for the Gundersen Health System Network is:

Gundersen Health Plan (GHP)
3190 Gundersen Dr.
Onalaska, WI 54650
Mailing Address:
Mail Stop-NCA2 01
1836 South Ave
La Crosse, WI 54601
(800)897-1923 or (608)775-8007
Fax (608) 775-8091
www.gundersenhealthplan.org

10. The ***Plan Supervisor*** or Pharmacy Benefit Manager for the *prescription* drug program is:

Navitus Health Solutions
1025 West Navitus Drive
P.O. Box 999
Appleton, WI 54912-0999
(866)333-2757
www.navitus.com

11. The **Mail Order Service Provider** for the *prescription* drug program is:

WellDyneRx
P.O. Box 4517
Englewood, CO 80155-4517
(866)490-3326
Fax (888)830-3608
www.welldynerx.com

12. **PPO *Network***:

Health Tradition (Mayo Clinic Health System-Franciscan Skemp)
(888)459-3020 or (608)781-9692
www.healthtradition.com

HealthEOS Plus by Multiplan Inc.
(when outside of the Health Tradition service area)
(800) 279-9776
www.healtheos.com

or

Gundersen Health System
(800)897-1923 or (608)775-8007
www.gundersenhealthplan.org

HealthEOS Select by Multiplan Inc.
(800) 279-9776
www.healtheos.com

13. The *Plan*'s *costs* may be shared by the *employer* and *employee, retiree* or *plan participant*. Benefits under the *Plan* are provided from the health fund assets. The level of any *participant contribution* is set by the *Plan* Administrator. The *Plan* Administrator reserves the right to change the level of *participant contributions*, except as otherwise specified in applicable collective bargaining agreements or as required by law. The *Plan* Administrator is prohibited to charge different *plan contributions* or *plan* costs to individuals based on health factors, whether or not it is the individual or the *Plan Sponsor* who pays the *plan contribution* or *plan* cost. In addition, a

group health *plan* may not establish a rule for eligibility or set any individual's *contribution* rate based on whether an individual is confined to a *hospital* or other health care institution.

14. Each *employee* of the *employer, retired employee* who participates in the *Plan,* or other *plan participant* receives a Summary *Plan* Description, which is in this booklet. This booklet will be provided to *employees* and *retirees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, and a description of the benefits provided and other *plan* information.

15. The *Plan Sponsor* reserves the right to amend, modify or terminate the *Plan, plan* benefits and/or *contributions* at any time, as indicated in this document, unless otherwise specified in applicable collective bargaining agreements. Significant changes to the *plan*, including termination, will be communicated to *participants* as required by applicable law.

16. Upon termination of the *Plan*, the rights of the *participants* to benefits are limited to claims incurred and payable by the *Plan* up to the date of termination. *Plan* assets, if any, will be allocated and disposed of for the exclusive benefit of the *plan participants* covered by the *Plan*, except that any taxes and administration expenses may be made from the *Plan* assets.

17. The *Plan* does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the *Plan* will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

18. This *Plan* is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the *Plan*, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

The Schedule of Benefits table found in the front pocket of this book is a summary of your benefits. Please review specific *plan* provisions within the document to ensure *you* understand the complete benefit(s).

The City of La Crosse Medical Benefit Plan, restated January 1, 2012 shall be amended as described herein. ***However, in the event the Federal or State of Wisconsin law requiring these amendments is repealed or amended at any time, the affected provision(s) will revert to the provision in the Plan that was in existence immediately prior to this change.***

UTILIZATION/*CASE MANAGEMENT*

Utilization management and *case management* are designed to assist *plan participants* in making informed medical care decisions resulting in the delivery of appropriate levels of *Plan* benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's *physician*. The patient and his or her *physician* determine the course of treatment. The assistance provided through these *services* does not constitute the practice of medicine. **Payment of *Plan* benefits is not determined through these processes.**

PRECERTIFICATION

For benefits to be payable under this *Plan*, most types of medical *services* must be determined to be *Medically Necessary* or *Functionally necessary* (dental *services*), based on the circumstances of the *plan participant*. *Precertification* is a process that informs the *plan participant* or treating Physician whether coverage will be available for specific medical *services* based on the specific needs of the *plan participant* at such time. Use of this process serves all parties.

Utilization/*Case Management* Programs are used by the *Plan* to help keep health cost down. These Programs are a way to review and advise *you* on how best to use your *Plan* benefits.

The Plan Supervisor will provide *Precertification* as required by *your Plan*. The *Plan Supervisor* recommends calling as soon as possible to receive proper *Precertification*. The *Plan Supervisor* toll-free number is located on *your* ID card.

This *Plan* recommends *Precertification* of non-*emergency* Inpatient *Confinement*s (i.e., *hospital*, chemical dependency treatment center, mental care center, sub-acute care center, *skilled nursing facility* or hospice provider) at least 24 hours prior to admissions and notification of *emergency confinement*s by the next business day following admission. This *Plan* recommends *Precertification* for a *hospital* length of stay in connection with *child*birth for the mother or newborn *child* of more than 48 hours following a vaginal delivery or more than 96 hours following a cesarean section.

Additionally, *Precertification* and prior authorization is recommended for outpatient surgeries performed in an outpatient *hospital* or surgical center, therapy *services* (i.e., radiation therapy, chemotherapy, dialysis treatments, physical therapy, respiratory therapy, occupational therapy, speech therapy and cardiac rehabilitation therapy phases I and II) for more than five visits per year, durable medical equipment, home health care, *chiropractic care* for more than 13 visits per *calendar year*, outpatient mental *illness* or chemical dependency for more than five visits per *calendar year*, immunizations for respiratory syncytial virus (RSV), dental restorative *services*, oral *surgery*, TMJ or other procedures as otherwise specified.

After *you* or *your qualified practitioner* has provided Medical Management with *your* diagnosis and treatment *plan*, Medical Management will:

1. Advise *you* in writing if the proposed treatment *plan* is *medically necessary*;

2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and

3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified,* the extension should be *precertified* through *concurrent review*.

If it is determined at any time *your* proposed treatment *plan*, either partially or totally, is not a *covered expense* under the terms and provisions of the *Plan*, benefits for *services* may be reduced or *services* may not be covered. *You* may appeal any such decision, as described in the Section of this *Plan* regarding claims and appeals

If treatment is to commence more than 90 days after the date treatment is authorized, Medical Management will recommend that *you* submit another treatment *plan*.

SECOND SURGICAL OPINION

A second surgical opinion may be obtained, but it is not required by the *Plan*. Benefits for the second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner*, are payable the same as any other *sickness.*

If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion.

The *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours.*

PREDETERMINATION OF MEDICAL BENEFITS

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*. The written request should contain the treatment *plan*, specific diagnostic and procedure codes, as *well* as the expected charges. Medical Management will provide a written response advising if the *services* are a covered or non-*covered expense* under the *Plan*, what the applicable *Plan* benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the *Plan* applicable at the time treatment is provided.

If treatment is to commence more than 90 days after the date treatment is authorized, Medical Management will recommend that *you* to submit another treatment *plan*.

CASE MANAGEMENT

Case management is a program whereby a case manager monitors patients with severe or ongoing conditions and explores, discusses and recommends coordinated and/or alternate types of appropriate *medically necessary* care. The case manager consults with the patient, the family and the attending *Physician* in order to develop a *plan* of care for approval by the patient's attending *Physician* and the patient. This *plan* of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring *Hospital* or *Skilled nursing facility*;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and *services*.

An alternate care option may be recommended when it will be beneficial and cost effective to both the patient and the *Plan*. If the alternate care option recommended is normally an excluded service, then it will be subject to review and approval by a third party physician service review prior to approval.

The case manager will coordinate and implement the *Case management* program by providing guidance and information on available resources and suggesting the most appropriate treatment *plan*. The *Plan* Administrator, attending *Physician*, patient and patient's family must all agree to the alternate treatment *plan*.

Once agreement has been reached, the *Plan* Administrator will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment *plan*, even if these expenses normally would not be paid

by the *Plan* **NOTE: *Case management* is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.**

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

PREFERRED PROVIDER (In-Network) AND FACILITY PLAN OPTION

Agreements have been made with certain providers and facilities of health care called preferred providers (PPO or In-network providers) and preferred facilities (PPO or In-network facilities). However, *you* may select any provider to provide *your* medical care, but *your* costs may vary depending on whether *you* choose a PPO (In-Network) or non-PPO (Out-of-network) provider.

The *Plan* offers *you* a choice of participating in one or the other of two local preferred provider *Networks.* You elect one of the Networks to apply to coverage for *you* and your *dependents.* The *Plan* allows you to make changes to your network election during an open enrollment period each fall with the change to be effective for the forthcoming calendar year.

Covered expenses for *services* provided from preferred and non-preferred providers and facilities are payable as shown on the Schedule of Benefits.

Covered expenses are payable on a *maximum allowable fee* basis.
When the amount of combined *covered expenses* paid by *you* and/or *your* covered *dependents* satisfy the out-of-pocket limits as shown on the Schedule of Benefits, the *Plan* will generally pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums of the *Plan.*

If *you* and *your* covered *dependents* use a combination of In-Network and Out-of-Network providers, the appropriate out of pocket amount applies to each type of provider and is not combined, unless specifically indicated on the Schedule of Benefits.

In-Network and Out-of-network covered expenses paid by the *Plan* aggregate to the *maximum benefit* (i.e. charges, *visit* limit or days) per *calendar year.*

If *emergency services* are received from an Out-of-Network *hospital*, *qualified treatment facility*, or *qualified practitioner*, all covered expenses are payable under the In-Network level of benefits.

In addition to the PPO *Networks*, the *City* or the *Plan* Supervisor may also arrange for other providers (which are located out of such *Network* service areas) to offer some financial discounts to the *Plan*. Such providers are not part of the PPO *Networks* and any related claims are covered at the level for out-of-*network services*.

TIMELY NOTICE OF CLAIM

Claims must be submitted as soon as possible after the date of the expense was incurred. In no event will a claim be accepted and paid beyond sixteen (16) months from the date of expense. In the event that a provider fails to submit a bill with complete information, *you* must act to provide such information to the *Plan Supervisor* in order to meet the sixteen month deadline.

SECTION I - MEDICAL *DEDUCTIBLE*, *CO-PAYMENT, COINSURANCE* and OUT OF POCKET LIMITS INFORMATION

MEDICAL *DEDUCTIBLE* AND *COINSURANCE*

Covered expenses are payable, after satisfaction of the *deductible,* if applicable, to *a maximum allowable fee* at the *coinsurance* percentages and up to the *maximum benefit*s shown on the Schedule of Benefits. The *deductible* and *coinsurance* amounts are not satisfied or lowered by any fixed-dollar copay amounts, any amounts exceeding the fixed-dollar and fixed-*visit* limits, excluded items, outpatient *prescription* drug costs or amounts exceeding UCR (when Out-of-network).

DEDUCTIBLE

The *deductible* applies to each *participant* each *calendar year*. Only charges which qualify as a covered expense may be used to satisfy the *deductible*. The amount of the *deductible* (and maximum family deductible if applicable) is stated on the Schedule of Benefits.

CO-PAYMENT

The term *co-payment* means the amount to be paid by *you* for each applicable medical service. The *co-payment*, if applicable, is applied before your *deductible* and *co-insurance*. *Co-payments* apply as shown on the Schedule of Benefits.

COINSURANCE

The term *coinsurance* means the shared financial responsibility for *covered expenses* between the *participant* and the *Plan*.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the *deductible*, if applicable, is satisfied each *calendar year*.

USUAL, CUSTOMARY & REASONABLE CHARGES

The *Plan* shall pay no more than the Usual, Customary & Reasonable Charge for *covered services* and/or supplies, after a deduction of all amounts payable by *coinsurance* or *deductible*s. All charges must be billed in accordance with generally accepted industry standards.

The Usual, Customary & Reasonable Charge shall be the average payment actually made for reasonably comparable *services* and/or supplies to all providers of the same *services* and/or supplies by all types of *plans* in the same market area during the preceding *Calendar Year*, adjusted by the National Consumer Price Index medical care rate of inflation. The *Plan* Supervisor shall determine the average *plan* payment made and applicable market area using reasonably available information. Claim data available to the *Plan Supervisor* is used as a basis for setting such maximums from time to time at the 85th percentile of the amounts in the local geographic market area.

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

Usual, Customary & Reasonable Charges do not apply to In *Network* benefits.

OUT-OF-POCKET LIMIT

When the amount of combined *covered expenses* paid by *You* and/or all *your* covered *dependents* satisfy the out-of-pocket limits the *Plan* will generally pay 100% of covered expenses for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums. See your applicable Schedule of Benefits for specific Out-of-Pocket information.

***Deductible*s, co-insurance, and out-of-pocket limits for In/Out-of-network are separate, unless specified otherwise on the Schedule of Benefits.**

MAXIMUM OUT-OF-POCKET (MOOP) is the most you could pay during a coverage period (calendar year) for your share of the cost of covered services. *Co-payments*, deductibles, and co-insurance incurred in network are included in the Maximum Out-of-Pocket limit.

SECTION II - COMPREHENSIVE MEDICAL BENEFITS

HOSPITAL BENEFITS

Subject to the limitations, exclusions and conditions of this *Plan*, a *Participant* is entitled to *covered services* described in this section in the amounts specified. *Hospital covered services* provided by a non-PPO provider are covered at *usual, customary and reasonable charges.*

Inpatient *hospital services*. *Covered services* include:

1. *Hospital* charges for daily semi-private, ward, *intensive care* or coronary care room and board charges for each day of *confinement.* A private room is covered if semiprivate room is not available, based on the below:

   The maximum eligible charge for non-intensive private room will not exceed the daily rate for the greatest number of semiprivate rooms in the *hospital* where confined. If the *Hospital* does not provide a semiprivate room for the particular *hospital* stay, the private room allowance shall not exceed the lesser of:

   a. The charge for the particular room occupied; or

   b. The average daily charge for all two-bed rooms in the area.

2. *Hospital* charges for *services* furnished for *your* treatment during *confinement*.

3. Nursing *services* for covered inpatient *hospital confinements* are covered as a benefit whether billed separately or as a part of the room and board charge and these nursing *services* shall not apply toward any daily room and board charge limitations.

4. Charges for ancillary *services* and supplies, including, but not restricted to:

   a. use of operating, delivery, and treatment rooms and equipment;

   b. prescribed drugs;

   c. administration of blood; blood and blood plasma, including a blood processing fee charged by the *hospital*, by a blood bank or blood center;

   d. anesthesia; anesthesia supplies and *services* rendered by a *qualified practitioner*;

   e. medical and surgical dressings, supplies, casts, and splints;

   f. *diagnostic services*; and

   g. therapy *services*.

Outpatient *hospital services*. *Covered services* are payable as shown on the Schedule of Benefits and include charges made by a *hospital* for:

1. ***Surgery services* and supplies:** *hospital* charges for removal of sutures, anesthesia, anesthesia supplies and *services* rendered by a *qualified practitioner* other than the surgeon or assistant at *surgery*.

2. ***Diagnostic service*s:** *hospital* charges for, including but not limited to, X-ray and other radiology *services*; laboratory and pathology *services*; cardiographic, encephalographic, and radioisotope tests; and, mammograms.

3. Regularly scheduled treatment such as, but not limited to, chemotherapy, inhalation therapy, or radiation therapy as ordered by *your* attending *physician*.

4. **Therapy *services*:** physical, speech and occupational therapy *services* by a registered therapist, provided the therapist does not ordinarily reside in the *participant*'s home and is not a *participant* of his or her immediate family.

5. ***Emergency* accident care:** *Hospital services* and supplies for the treatment of traumatic bodily injuries resulting from an accident.

6. ***Emergency* medical care:** *Hospital services* and supplies for the treatment of a sudden onset of a medical condition which shows itself by acute symptoms. The symptoms must be severe enough that, without immediate medical attention, they could reasonably cause:

    a. the *Participant*'s health to be permanently placed in jeopardy;

    b. other serious medical consequences;

    c. serious impairment to bodily functions; or

    d. serious and permanent dysfunction of any bodily organ or part.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility, are payable.

HUMAN ORGAN AND TISSUE

The *Plan* provides benefits for human organ and tissue transplants when *medically necessary*, as precertified by the *Plan* or other procedures as determined to be medically appropriate*, non-experimental* and part of the global fee. Transplants that are determined by the *Plan supervisor* to be *experimental, investigational or for research purposes* are not covered.

Transplants are subject to all provisions of the *Plan* applicable at the time the expense is incurred, including but not limited to, the limitations and exclusions and the definitions found in this *Plan* and the following additional *Plan* provisions:

1. When both the recipient and the donor are covered by the *Plan*, each is entitled to the benefits of the *Plan*;

2. When only the recipient is covered by the *Plan*, the recipient is entitled to the benefits of the *Plan*. The donor's benefits are limited to only those eligible charges for *services* to donate the tissue, joint or human organ and not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage, medical *Plan* or any government program. Benefits provided to the donor are charged against the recipient's coverage under the *Plan*;

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

4. If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to the evaluation and procurement are covered for the recipient up to the benefit limitation of the *Plan*.

CENTERS OF EXCELLENCE TRANSPLANT

A Centers of Excellence Transplant Program is available under this *Plan.* Although not required, *you* are encouraged to utilize this program, which offers one-third to two-thirds savings on transplant costs. By using the program, *you* can increase *your* savings and the *Plan*'s without sacrificing quality of care. Please contact the *Plan Supervisor* for further information.

AMBULANCE SERVICE

Charges for professional ambulance service when *medically necessary* and the *participant's* condition does not permit the use of other methods of transportation are payable, subject to *deductible* and *coinsurance* provisions of the *Plan* as specified in the Schedule of Benefits. The ambulance must be used to provide local transportation for a sick or injured *Participant*, to, but not returning from a *hospital* or *skilled nursing facility*, a *participant*'s home or scene of an accident or *medical emergency*. The ambulance must meet state staffing requirements. Air ambulance is further restricted to life threatening situations and covers transport to a medical facility qualified to provide *medically necessary* care of the *participant*. "Local" means the metropolitan area in which the insured is located at the time service is used. If the person is in a rural area, "local" means the nearest medically appropriate facility. Ambulance service to transport the patient to a different facility for the convenience of *family members* or others is not a covered benefit.

SURGICAL AND MEDICAL BENEFITS

Subject to the limitations, exclusions and conditions of this *Plan*, a *participant* is entitled to *covered services* payable as shown on the Schedule of Benefits when rendered by a *qualified practitioner* acting within the scope of their respective licenses and incurred for:

Surgical *services*

1. A surgical procedure, including pre-operative and post-operative care. If multiple or bilateral surgical procedures are performed at one operative session, the *Plan Supervisor* follows multiple surgical procedures as outlined in the Current Procedural Terminology (CPT) book, which could reduce benefit payments.

2. Diagnostic X-ray and laboratory *services* necessary for the diagnosis of and related to covered surgical procedures. If a PPO provider refers *your* diagnostic x-rays or laboratory tests to a non-PPO provider for reading or interpretation, the charges for the non-PPO provider are payable at the PPO level of benefits.

3. Professional *services* of a radiologist or pathologist for diagnostic x-ray or examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy.

4. Other covered medical *services* received from or at the direction of a *qualified practitioner*.

5. Anesthesia: includes anesthesia, anesthesia supplies and *services* including topical and infiltration anesthesia, rendered by a physician other than the surgeon or assistant at *surgery* in connection with *services* otherwise covered by the *Plan.*

6. Reconstructive *surgery*: *surgery* to restore bodily function or correct deformity resulting from disease, trauma, or a previous therapeutic process that is a c*overed service* under this *Plan*. This includes coverage for *surgery* subject to the provisions of the Women's Health and Cancer Rights Act. The disease, trauma, or therapeutic process must have occurred after the *participant*'s *effective date* and while the *participant* is continuously covered under the *Plan*. Transsexual *Surgery* is excluded from coverage.

7. Congenital birth defect *surgery*: *surgery* which provides functional repair or restoration of any congenital or developmental defective body part when repair is necessary to achieve normal body functioning. The defect must have existed at birth.

8. Sterilization (male or female): covered regardless of *medical necessity*. Reversal of sterilization is not covered.

9. Cochlear implants: Charges are covered for cochlear implants for children under age eighteen (18). Device, *surgery* for implantation of the device, follow-up sessions to train on use of the device and *hospital* facility charges when *Medically Necessary* and Prior Authorized by the Medical Plan are covered subject to in or out of network *deductible* and *coinsurance* levels. Hearing aid coverage is limited to a maximum of one per *child* under age eighteen (18), per ear every three (3) years. A *cochlear implant* is a device implanted in the ear to facilitate communication for the profoundly hearing impaired. This coverage will be provided in accordance with the terms and conditions of Wis. Stat. 632.895(16) including the definition of a licensed provider, covered items, limitations, exclusions, etc.

10. Oral *surgery*: Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are limited to the following:

    a. Surgical exposure or removal of impacted unerupted teeth.

    b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

    c. Surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such *services* are performed within six months of such *injury*.

    d. Apicoectomy - excision of apex of tooth root.

    e. Excision of exostosis (bony growth) of the jaws and hard palate.

    f. Treatment of fractures of facial bones within six months of such *injury*.

    g. External incision and drainage of cellulitis.

    h. Incision of accessory sinuses, salivary glands or ducts.

    i. Gingivectomy - excision of loose gum tissue to eliminate infection.

    j. Alveolectomy – (removal of part of the dental alveolar process to take out a tooth) or alveoplasty (smoothing the jawbone when one or more permanent natural teeth are lost due to extraction, *injury* or accident, each absent tooth leaves a hole in the jawbone) if performed for reason other than preparation for dentures or dental implants or excluded types of procedures.

    k. Frenectomy - incision of any mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue.

    l. Removal of retained (residual) root.

    m. Gingival curettage (scraping the gums or tooth sockets after extraction, or cyst cavities to remove inflamed and diseased tissue).

    n. Apical (part of the tooth near the end or tip of the root) curettage (scraping the apex to remove inflamed and diseased tissue).

    o. Osseous *surgery*

p. Root canal therapy and related filling, or crown within six months thereafter regardless of whether such crown was necessary due to such tooth being defective at such time.

q. Surgical treatment for the correction of temporomandibular joint (TMJ) disorders. Prior authorization is recommended for surgical or non-surgical TMJ *services*, but it is not required. Treatment, *services* and supplies include:
   1) history, *exam* and diagnosis,
   2) anesthesia *services* for surgical correction of TMJ,
   3) the following types of *Surgery* for TMJ: arthroscopy, arthrotomy, eniscectomy, condylectomy, coronoidectomy, excision of, and reduction for dislocation of, the temporomandibular joint,

r. *Medically necessary surgery* for the correction of functional deformities of the maxilla or mandible if all of the following apply:
   1) the condition is caused by: developmental or required deformity, disease or *Injury*,
   2) the procedure is reasonable and appropriate for the diagnosis or treatment for the condition, and
   3) the purpose of the procedure or device is to control or eliminate: infection, pain, disease or disorder.

11. Assistant at surgery: includes a physician or a certified physician's assistant who actively assists the operating surgeon in the performance of a covered *surgery*, when the *Plan* determines such *services* to be *medically necessary* based on the *surgery*'s complexity or the patient's medical condition. The *maximum allowable fees* for the assistant at *surgery* shall be 25% of the primary surgeon for a Physician (MD) or 10% for a Physician Assistant (PA).

12. Inpatient consultation: includes consultation *services* when rendered to a *hospital* inpatient by another physician at the request of the attending physician. Consultation does not include staff consultations which are required by *hospital* rules and regulations.

Non-surgical inpatient *services*

Benefits are provided for the *services* listed below if rendered by a physician or *qualified practitioner* to a *participant* who is a *hospital* inpatient for a condition not related to *surgery* or *pregnancy*, anesthesiology, pathology or radiology.

1. Medical care visits: medical care rendered to a *participant* who is an inpatient is limited to one (1) charge per day per *qualified practitioner*.
2. Intensive medical care: medical care rendered to an inpatient *participant* whose condition requires a physician's constant attention and treatment.

3. Consultation: consultation *services* when rendered to a *hospital* inpatient by another physician at the request of the attending physician. Consultation does not include staff consultations which are required by *hospital* rules and regulations.

4. Newborn consultation: care for an infant born in an apparently normal healthy state is limited to an inpatient *exam* only, by a physician other than the delivery physician. Subsequent medical care inpatient visits, when *medically necessary* for the treatment of an *Illness* or *injury* of the newborn is covered provided the newborn is a *participant* under this *Plan.*

Outpatient medical *services*

Benefits are provided for *covered services* rendered by a physician or *qualified practitioner* to a *participant* who is an outpatient for a condition not related to *surgery*.

1. *Diagnostic Services*: *Diagnostic Services* include, but are not limited to: X-ray and other radiology *services*; laboratory and pathology *services*; cardiographic, encephalographic, and radioisotope tests; and, mammograms. NOTE: If a PPO provider refers *your* diagnostic x-rays

or laboratory tests to a non-PPO provider for reading/interpretation, the charges for the non-PPO provider are payable at the PPO level of benefits**.**

2. Therapy Services: includes Radiation Therapy for any conditions. Physical, Speech and Occupational Therapy *services* by a registered therapist are covered, provided the therapist does not ordinarily reside in the *Participant*'s home and is not a *member* of his/her immediate family.

3. Physician *Services*: Medical Care for examination, diagnosis and treatment of an *injury* or *Illness*. Includes routine or periodic physical examinations.

4. Anesthesia: includes anesthesia, anesthesia supplies and *services* including topical and infiltration anesthesia, rendered by a Physician other than the surgeon or assistant at *Surgery* in connection with *services* otherwise provided for herein.

5. Dental Services: Dental *services* includes the following:

a. X-rays and/or exams when related to a covered dental procedure or a covered oral surgery.

b. Major Restorative: Simple non-cutting extraction of a natural erupted tooth with the initial replacement with an artificial tooth including initial partial dentures or bridgework when such replacement is *functionally necessary for each extracted tooth*, as determined by the *Plan Supervisor*.

c Other limited types of oral *surgery* as specified under *surgery*.

d. Surgical or Non-surgical treatment for the correction of temporomandibular joint (TMJ) disorders Prior authorization is recommended. for surgical or non-surgical TMJ *services*, but it is not required.

Coverage is available if all of the following apply:

(1) The condition is caused by congenital, developmental or acquired deformity, disease or *injury*.
(2) Under the accepted standards of the profession of the *qualified practitioner* rendering the service,
(3) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
(4) The purpose of the procedure or device is to control or eliminate infection, pain, disease or disorder.

Coverage does not include *Cosmetic* or elective orthodontic care, periodontic care or general dental care.

e. Setting of fractures of the jaws;

f. Basic Restorative: Repair or replacement of a natural tooth due to *injury* by blunt external force other than chewing within six months of such *injury*, when such replacement is *functionally necessary* as determined by the *Plan Supervisor*.

g. *Hospital* or *Ambulatory Surgery Center* charges and anesthetics for Dental Care. Benefits are provided for *hospital* or *ambulatory surgery center* charges incurred, and anesthetics provided in conjunction with dental care that is provided to a *Participant* in a *hospital* or *ambulatory surgery center*, if any of the following apply:

(1) The *participant* is a *child* under the age of 5;

(2) The *participant* has a chronic disability that meets all of the conditions under S.230.04 (9) (a) 2.A.,b. and c., Wis. Statutes; or

(3) The *participant* has a medical condition that requires hospitalization or general anesthesia for dental care.

6. <u>*Chiropractic Care*</u>: *Chiropractic care* for treatment of a *bodily injury* or *sickness* is payable as shown in the Schedule of Benefits. *Services* are limited to the treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere in the body. No benefits will be paid for maintenance *chiropractic care*, except to the extent allowed for out-of-network chiropractic *services* up to the specified limits indicated on the Schedule of Benefits. On an in-network basis, no benefits will be paid for charges related to routine *chiropractic care* such as adjustments that are not directly related to disability.

7. <u>*Genetic Services*</u>: For claims to be considered for payment under this section, services must be prior-authorized. See Section III "Limitations and Exclusions" for a list of Genetic Services Exclusions. Covered Genetic Services **MAY** include:

   a. Genetic counseling provided to you by a physician, a licensed or Masters trained genetic counselor or a medical geneticist;

   b. Amniocentesis during pregnancy;

   c Chorionic Villus sampling for genetic testing and non-genetic testing during pregnancy;

   d Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents IS NOT covered unless your physician provides a justification for including each test in the panel;

   e Compatibility testing for a covered person who has been approved by us for a covered transplant;

   f Cystic Fibrosis testing as recommended by the American College of Medical Genetics;

   g Molecular Genetic Testing of pathological specimens. Such testing does not include any testing of blood, except testing for the diagnosis of Leukemia or Lymphoma. All other molecular testing of blood or body fluids require prior authorization unless the test is otherwise specified and pre-authorized by the Plan. Please note that many molecular tumor profiling tests or panel tests are not covered.

   h. BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations and testing has been recommended after receiving genetic counseling;

   i All other genetic testing for which you receive prior authorization. Plan Supervisor MAY authorize genetic testing if the ordering health care provider shows that the results of such testing will directly impact your future treatment. Your physician must describe how and why, based on the results of the genetic testing requested, your individual treatment plan would be different than your current or expected treatment plan based on a clinical assessment without genetic testing. Upon request, the ordering health care provider must submit information regarding the genetic testing's clinical validity and clinical utility. Genetic testing that the Plan considers experimental/investigational/unproven will not be covered. Plan Supervisor will only accept prior authorization from the ordering health care provider (e.g. your physician); and will NOT accept prior authorization requests from the laboratory that will perform the genetic services.

   j. Genetic testing for predisposition or carrier status for a genetic disorder when a certified genetic counselor has determined it is likely that you carry a gene mutation that substantially increases your risk of developing the disorder and the presence of a mutation will lead to modifications in future medical care.

ROUTINE CARE

You or *your* covered *dependent* may be eligible for the following routine *covered services* without *medical necessity*, subject to all terms and provisions of the plan.

Routine care includes preventive *services* for screenings for plan participants when determined to be appropriate for related health risk include, but are not limited to:

1. Physical health examination;

2. Well-baby *exams* and associated lab *services* up to age two;

3. Routine physical *exams*, including school required physical *exams*, vision and hearing *exams* after age 2.

4. Pap smear cervical cytology;

5. Mammography;

6. Prostate specific antigen/digital rectal *exam*.

7. Blood pressure;

8. Bone mineral density;

9. Chlamydia screen;

10. Colonoscopy or Sigmoidoscopy

11. Fasting blood sugar;

12. Fasting total lipid profile;

13. Fecal occult blood and sigmoidoscopy/barium enema, and one sigmoidoscopy/barium enema screening;

14. Hearing *exam*;

15. Eye *exam*;

16. Blood lead tests for children under six years of age conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the Wisconsin Department of Health and Family Services.

17. Routine EKG is limited to one baseline test per *participant* at age 18 and older.

18. Vaccines and immunizations

    c. Preventive Immunizations for adults age 18 and older include, but are not limited to:

        1) Influenza, Pneumococcal, Tetanus-Diphtheria-Pertussis (whooping cough) Td or Tdap, Meningococcal, and immunizations required for travel purposes or when attending college, Zoster for *participants* age 60 and older, Varicella (chickenpox), Measles-Mumps-Rubella (MMR), Human Papillomavirus (HPV) for women 26 years or younger or any adult immunizations consistent with the criteria established and recommended by the Advisory Committee on Immunization Practices.

        2) **Routine immunizations for Lyme disease are excluded.**

d. Preventive Immunizations for children, up to age 18 follow the guidelines established by the Advisory Committee on Immunization Practices and include but are not limited to:

1) Hemophilus influenza B

2) Tetanus toxoid

3) Measles Mumps Rubella MMR

4) Poliovirus vaccine

5) DTap/Tdap (Diptheria, Tetanus, Pertussis) vaccine

6) Varicella virus vaccine (chickenpox)

7) Hepatitis B vaccine

8) Pneumococcal conjugate (PCV)

9) Meningococcal vaccine (MCV4)

10) Rotavirus RV

11) Human Papillomavirus vaccine (HPV)

12) Hepatitis A

13) Shingles vaccine

14) Influenza

15) **Routine immunizations for Lyme disease are excluded**.

Routine care benefits do not include the following:

1. Any dental examinations;
2. Medical examination for *bodily injury* or *sickness*; or
3. Medical examination caused by or resulting from *pregnancy*.

PREGNANCY BENEFITS

Pregnancy is a *covered expense* for any *covered person* payable as any other *illness*.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

In accordance with federal law, benefits for the inpatient *hospital* stay, in connection with childbirth for the mother or newborn *child*, may not be restricted to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider after consulting with the mother, from discharging the mother or newborn earlier than 48 hours, or 96 hours as applicable. In any case, the *Plan* may not, under Federal Law, require that a provider or *plan participant* obtain authorization from the *Plan* for prescribing a length of stay not in excess of 48 hours, or 96 hours as applicable.

Newborn benefits**:** Benefits for newborns are subject to the *effective date* of coverage, as well as all terms and provisions of the *Plan*.

Adding a Newborn:
In order for a newborn to be covered from date of birth, a health plan enrollment form must be completed and submitted to the *Plan* Administrator within 31 days following the date of birth (see Enrollment section). Reporting the birth by phone or through a Family Medical Leave Request does not add the baby to the *Employee*'s or *Retiree's* coverage. Failure to submit an enrollment within the required deadline would result in the newborn becoming a *Late Applicant* and the *effective date* of coverage would be delayed.

Covered expenses incurred during a newborn *child's* initial inpatient *hospital confinement* include *hospital* expenses for room and board and miscellaneous service; *qualified practitioner*'s expenses for circumcision; and *qualified practitioner*'s expenses for routine examination before release from the *hospital*.

Birthing centers: *Expense incurred* within 24 hours after *confinement* in a *birthing center* for *services* and supplies furnished for prenatal care and delivery of *child*(*ren)* are payable.

SKILLED NURSING FACILITIES

*Covered expense*s for a *skilled nursing facility confinement* are payable when the *confinement*:

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;

2. Occurs while *you* or an eligible *dependent* are under the regular care of the *physician* who precertified the required *skilled nursing facility confinement*

Skilled nursing facility means only an institution licensed as a *skilled nursing facility* and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A *physician*'s *services* available at all times;

3. 24-hour skilled nursing *services* under the full-time supervision of a *physician* or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A *utilization review plan*.

A *skilled nursing facility* is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorder*s, chemical dependence or alcoholism.

Benefits: *Expense incurred* for daily room and board and general nursing *services* for each day of *confinement* in a *skilled nursing facility* is payable. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social *Services*.

Limitations: The *participant* is entitled to a maximum of 60 days per *calendar year*. Admission must occur within 24 hours of release from an acute care facility and must be in lieu of continued *hospital* stay.

HOME HEALTH CARE

Definitions.

For the purpose of Home Care benefits only, the following terms, when used herein, are defined as follows and limited to that meaning only:

1. **Home Care:** the *medically necessary* care and treatment of a *plan participant* under a *plan* of care established, approved in writing and reviewed at least once every sixty (60) calendar days by the attending Physician, unless the attending Physician determines that a longer interval between reviews is sufficient.

2. **Home Care Services:** one or more of the *services* described under "Benefits" below, provided or coordinated by a state-licensed or *Medicare*-certified home health agency or rehabilitation agency.

3. **Home Care Visit:** any one (1) *visit* by a person who either,

   a. provides *services* under a Home Care Plan;

   b. evaluates the need for Home Care; or,

   c. develops a plan for Home Care.

4. Each four (4) consecutive hours, or fraction thereof, of home health aide service in any one 24-hour period shall constitute one Home Care Visit.

Benefits.

Subject to the conditions and limitations which follow, and in accordance with this section the *Plan* provides home care benefits as follows:

1. Home nursing care rendered by, or under the supervision of a registered nurse, either on a part-time basis or intermittently.

2. Home health aide *services* which are *medically necessary* as part of the home care plan and which are rendered under the supervision of a registered nurse or medical Social Worker, certified nurse practitioner or Physician either on a part-time basis or intermittently. Such *services* consist solely of caring for the *Participant*.

3. Physical, respiratory, occupational or speech therapy.

4. Medical supplies, drugs and medications prescribed by a *physician*, and laboratory *services* by or on behalf of a *hospital*, if necessary under the Home Care Pan, and to the extent such items would have been covered under the Plan had the *participant* been hospitalized.

5. Nutrition counseling provided by or under the supervision of a registered dietician where such *services* are *medically necessary* as part of the home care plan.

6. Evaluation of the need, and development of a plan, for home care by a registered nurse, a Physician extender or medical Social Worker, when approved or requested by the attending Physician.

Conditions and limitations.

The following conditions and limitations apply to home care benefits:

1. Certification: Home care benefits are available only upon certification by the attending *physician* that:

   a. Hospitalization or *confinement* in a *skilled nursing facility* would otherwise be required if home care was not provided.

b. *Medically necessary* care and treatment are not available from other persons of a *participant*'s immediate family (including spouse, children, parents, grandparents, brothers and sisters of the *participant* and their spouses) or other persons residing with the *participant*, without causing undue hardship.

c. The home care *services* are provided or coordinated by a state-licensed or *Medicare*-certified home health agency or rehabilitation agency.

d. If the *Participant* was hospitalized immediately prior to the commencement of home care, the home care plan also shall be initially approved by the *physician* who was the primary provider of *services* during the hospitalization.

e. The *participant* requires on an intermittent basis, nursing *services*, therapy, or other *services* provided by a Home Health Care provider.

2. Limitations:

a. The *participant* is entitled to a maximum of forty (40) home care visits during any consecutive 12 month period unless the treatment plan would demonstrate that additional visits are in lieu of extended stay in a *skilled nursing facility* or *hospital*.

b. The maximum weekly allowance for home care coverage will not exceed the *usual and customary* weekly cost for care in a *skilled nursing facility*.

Exclusions.

Home care benefits do not include the following:

1. Food, housing, homemaker *services*, home-delivered meals;

2. Any *services* not specifically listed above under home care benefits;

3. *Services* or supplies not included in the home care plan established for the *participant*;

4. *Services* provided by *member*s of the *participant*'s immediate family or any other person residing with the *participant*;

5. *Custodial care*;

6. Charges for mileage, transportation or travel time to and from the *participant*'s home;

7. Wage or shift differentials for home health care providers; or

8. Charges for supervision of home health care providers.

9. *Services* of any social worker.

10. Care for tuberculosis.

11. Care for deafness or blindness.

12. Custodial *services*.

13. Care for senility or mental deficiency or retardation, mental illness or chemical dependency.

HOSPICE CARE

Hospice care benefits are provided under a *hospice care plan.* Hospice care provides palliative and supportive care to the terminally ill *participant*, and offers supportive care to the family of the hospice patient.

For hospice *services* only, *your* immediate family is considered to be *your* parent, spouse, and *your* children or stepchildren.

Hospice *services* must be furnished under a qualified *hospice care plan* either in a *hospice unit* or in *your* home. A *qualified practitioner* must certify the *participant* is terminally ill with a life expectancy of six months or less. Hospice Care Benefits are limited to 180 daily visits per lifetime.

Benefits.

Covered expenses are payable for the following hospice *services*:

1. Room and board and other *services* and supplies:
2. Part-time nursing care by or supervised by an R.N. for up to 8 hours per day;
3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family.
4. Medical social *services* provided to *you or your* immediate family under the direction of a *qualified practitioner*, which include the following.
    a. Assessment of social, emotional and medical needs, and the home and family situation,
    b. Identification of the community resources available, and
    c. Assistance in obtaining those resources;
5. Nutritional counseling;
6. Physical or occupational therapy;
7. Part-time home health aide service for up to 8 hours in any one day;
8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*, and
9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family.

Conditions and limitations.

Hospice care benefits do not include:

1. private duty nursing *services* when confined in a *hospice unit*;
2. a *confinement* not required for paid control or other acute chronic symptom management;
3. funeral arrangements;
4. financial or legal counseling, including estate planning or drafting of a will;
5. homemaker or caretaker *services*, including a sitter or companion *services*;
6. housecleaning and household maintenance;
7. *services* of a social worker other than a licensed clinical social worker;
8. *services* by volunteers or persons who do not regularly charge for their *services*; or

9. *services* by a licensed pastoral counselor to a *member* of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

Expense incurred by *you* during a *Plan* of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*,

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*.

Mental illness is a pathological state of mind producing clinically significant psychological and or physiological symptoms together with impairment in one or more major areas of functioning. This includes the conditions and diseases listed in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

Chemical Dependency means the individual's pathological and continuing use of mood altering substances, including alcohol, which:

1. the individual is unable to discontinue or control, without physiological and psychological symptoms resulting from substance withdrawal or voluntary abstinence; and

2. has resulted in dysfunction in one or more areas of the individual's life.

Inpatient and transitional *mental disorder* benefit. Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility*, or received for transitional treatment arrangements, are payable as shown on the Schedule of Benefits.

Transitional treatment arrangements mean covered expenses for the treatment of *mental disorder*s that are provided to *you* in a less restrictive manner than are inpatient *hospital services*, but in a more intensive manner than are outpatient *services* (includes but is not limited to day hospitalization).

Outpatient *mental disorder* benefits. Covered expenses for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown on the Schedule of Benefits.

Inpatient chemical dependence or alcoholism benefits. Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown in the Schedule of Benefits.

Outpatient chemical dependence or alcoholism benefits. Covered expenses for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown in the Schedule of Benefits.

Transitional chemical dependence or alcoholism benefits. Covered expenses received for transitional treatment arrangements are payable as shown in the schedule of Benefits.

Transitional treatment arrangement means covered expenses for the treatment of chemical dependence or alcoholism that are provided to *You* in a less restrictive manner than are inpatient *hospital services*, but in a more intensive manner than are outpatient *services* (includes but is not limited to day hospitalization).

Limitations on *mental disorder*, chemical dependence or alcoholism benefits

No benefits are payable under this provision for *services* and supplies which are rendered in connection with mental *illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human *Services*, or extended beyond the period necessary for evaluation and diagnosis of

learning and behavioral disabilities or for mental retardation; marriage counseling or court-ordered behavioral health *services*.

Treatment must be provided for the cause for which benefits are payable under provisions of the *Plan*.

OTHER COVERED MEDICAL SERVICES

The following are other *covered services* payable as shown on the Schedule of Benefits:

1. Durable Medical Equipment. Includes the following:

    a. Equipment prescribed by a Physician when approved by the *Plan Supervisor* as appropriate for treatment as required for therapeutic use.

    b. The rental (but not to exceed the purchase price) or, at the option of the *Plan*, the purchase of *durable medical equipment (DME)* when prescribed by a *qualified practitioner* and required for therapeutic use. Repair, maintenance or duplicate DME rental is not considered a covered expense unless a repair is needed to restore proper function.

    c. Artificial limbs and eyes and initial breast prostheses following a mastectomy (performed for one of the following reasons: carcinoma; fibrocystic disease; non-malignant tumors; traumatic *injury* or prophylactic indications) and prosthetic devices (including artificial limbs) and supplies which replace all or part of an absent body organ (including contiguous tissue) or the function of a permanently inoperative or malfunctioning bodily organ. A standard limb prosthesis is eligible, and for the purchase of more deluxe "special items", the dollar amount of a standard prosthesis (that is **not** purchased) may be applied towards the more deluxe device. Replacement is covered if initial device is not functional due to normal wear or growth of natural limb.

    d. Self-transport coverage is limited to one form such as a wheelchair, stroller and scooter. Electric-powered devices are **not** eligible when a manual device is sufficient for the *plan participant*.

    e. Orthopedic types of appliances such as:

        i. Casts,
        ii. Splints,
        iii. Strapping.
        iv. Orthosis (sacroil, lumbar, lumbar-sacral, cranial, cranial cervical, cervical, thoracic, thoracic-lumbar surgical, scoliosis, hip, femur, knee, ankle, tibial, femoral) required due to contractures;
        v. Custom-molded orthotics when determined to be *Medically Necessary* as determined by the *Plan Supervisor* or where one or more of the following diagnoses applies:

            1) Anomalies of Foot, not elsewhere classified
            2) Tarsal Coalition secondary to rigid flat foot
            3) Cerebral Palsy
            4) Charcot Marie Tooth
            5) Congenital Musculoskeletal Foot Deformities
            6) Varus Deformities of Feet
            7) Valgus Deformities of Feet
            8) Other Deformities of Feet
            9) Diabetes Mellitus
            10) Hallux Rigidus
            11) Morton's Metatarsalgia, Neuralgia or Neuroma
            12) Peripheral Enthesopathies and Allied Syndromes

13) Achilles Bursitis or Tendinitis
14) Tibialis Tendinitis
15) Calcaneal Spur
16) Peroneal Tendinitis
17) Peripheral Vascular Disease
18) Of native arteries of the extremities
19) Of bypass graft of the extremities
20) Generalized and unspecified atherosclerosis
21) Peripheral Vascular Disease, unspecified
22) Juvenile osteochrondosis
23) Plantar Fascial Fibromatosis/Plantar Fasciitis
24) Scleroderma
25) Severe Rheumatoid Arthritis
26) Spina Bifida including Myelomeningocele
27) Stress Fracture (
28) Tarsal Tunnel Syndrome
29) Chondromalacia of Patella
30) Enthesopathy of Specified Site
31) Keratoderma, Acquired
32) Osteoarthrosis, Unspecified
33) Other Acquired Deformities of Ankle and Foot
34) Tenosynovitis of Foot and Ankle
35) Traumatic Arthropathy, Ankle and Foot

These do **not** include special custom-molded shoes or devices to protect the feet unless:

1) The device is a permanent part of an orthopedic leg brace or the *Plan Supervisor* determines that *surgery* may be prevented
2) There is a patient history of poorly healing foot ulcers
3) Advanced polyneuropathy with a high risk of ulceration and/or infection exists
4) Spina Bifida
5) Foot deformities, congenital or rigid developmental.

Orthotics used solely for the purposes of athletics are not a covered benefit.

Replacements are covered only as specified below:

Adult: orthotic replacement will be considered for coverage if it is determined the replacement is *medically necessary* to control the *participant's* symptoms.

Pediatric: Orthotic replacement due to physical growth will be covered as necessary.

f. Crutches, canes, walkers and related attachments.

g. Durable diabetic equipment including glucometers, insulin infusion pumps and the installation and use of an insulin infusion pump, and related supplies. This benefit is limited to the purchase of one pump per person per *Calendar Year*. A *Participant* must use the pump for at least 30 days before the pump is purchased. The *Plan* will also pay for charges for diabetic self-management education programs. Automated injection devices are excluded. Eligibility for an insulin pump is contingent on meeting all of the following criteria:

i. Type I diabetes;
ii. A trial of a minimum of three to four daily injections of insulin yet continue to be in poor control despite good compliance with an intensive insulin regimen; and
iii. Highly motivated, able and willing to check blood sugar levels frequently during

the day, able and willing to make adjustments in their insulin program depending on their diet, activity and other factors.

h. Prothrombin home testing system is eligible when one of the following criteria applies:

   i. *Participant* must have been anticoagulated for at least three months prior to use of the home monitoring TNR device.
   ii. *Participant* has a condition that requires long term (i.e., greater than one year) anticoagulation (e.g., mechanical heart valve replacement, deep vein thrombosis, and atrial fibrillation)
   iii. *Participant* is judged to be a candidate for this approach to care. This assessment is based on, but not limited to, factors such as severity of disability, instability of control; prior history of, or high risk for complications of anticoagulation (e.g., bleeding or thrombosis). Coverage is limited to weekly testing unless otherwise indicated by ordering physician.
   iv. *Participant* is competent to perform determinations and should undergo an educational program on anticoagulation and the device.

i. Breast pump: purchase of a basic electric breast pump or basic manual breast pump, each pregnancy every 12 months plus all breast pump supplies including tubing, connectors, breast shields, breast shield inserts, collection bottles, valves and membranes. These may be obtained through an in network provider of Durable Medical Equipment and billed to your medical plan or through a non-network retail store and reimbursed through your medical benefit plan.

j. CPAP/BIPAP is eligible when one of the following criteria applies:

   i. *Participant* has a diagnosis of obstructive sleep apnea syndrome (as defined as apneahypopnea index (AHI) or respiratory disturbance index (RDI) greater than 20 or an apnea-hypopnea index (AHI) or respiratory index (RDI) greater than 10 and daytime hypersomnolance objectivity documented by:
      1) A multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 10 minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day; or
      2) An Epworth score of 10 or greater minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day.
   ii. *Prescription* CPAP/BIPAP is written by a pulmonologist or a sleep disorder *specialist*.
   iii. Initial prior authorization approval will be for one month. Follow up with the pulmonologist will be required for additional rental or for the rent-to-purchase option.

k. Oxygen therapy is eligible when one of the following criteria applies:

   i. For cluster headaches when prescribed by a neurologist;
   ii. When 02 saturation 88% or P02 is less than 55mm HG at rest or with activity;
   iii. When 02 saturation 89% or P02 is less than 59 mm Hg in patients with CHF, edema, or cor pulmonale.

l. Enteral therapy (tube feeding) is eligible when one of the following criteria applies:

   i. Such feedings would be the *participant's* sole source of nutrition.
   ii. The *participant* must have a permanent tube (i.e., gastrostomy) for the administration of the enteral feeding.
   iii. Feedings must be ordered by the attending Physician and/or a Dietitian on a yearly basis for *participants* with a lifetime need for enteral feedings. Feedings will be approved to be dispensed in one-month intervals.

m. Bilirubin light to treat a newborn with signs and symptoms of jaundice

n. Continuous Passive Motion Device as required due to a total knee replacement.

o. Electric hospital-type or semi-electric beds with head and foot adjustment and total electric beds (head, foot and height adjustments) when required due to disability that requires frequent changes in body position or the need for immediate changes in body position, and the *participant* is significantly impaired ability to get into and out of a normal bed.

p. Nebulizer

q. Pulse oximeter device to determine oxygen concentration in arterial blood.

r. Transcutaneous Electric Nerve Stimulation or Neuromuscular Electric Stimulization device that applies mild electrical stimulation to skin electrodes which are placed over a painful area, when used to control chronic intractable pain.

s. Fetal monitor

t. Seat-lift chair when covered person shall benefit therapeutically from use, meaning it is likely to affect improvement, arrest or retard deterioration of the *participant's* disability, and that the alternative would be char or bed *confinement*.

When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. When determining whether to repair or replace the Durable Medical Equipment and related supplies, the *Plan* will consider whether:

i. The equipment/supply is still useful or has exceeded its lifetime under normal use; or
ii. The *participant's* disability has significantly changed so as to make the original equipment inappropriate (e.g., due to growth or development).

2. Eye care.

a. Following cataract *surgery*, c*overed services* are limited to the vision examination and initial purchase of eyeglasses or contact lenses for aphakia, and keratoconus.

b. One routine vision examination is covered up to a *maximum payment* of $80.00 per *calendar year per person*. Limitation is waived for one routine vision examination for *participants* through age 18.

Vision materials and *services* to vision materials are not covered under this benefit unless specifically provided.

3. Hearing Aids for Children under Age 18: Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per *child*, per ear every three (3) years.

4. Diabetic care. *Services*, equipment and supplies needed for the treatment of diabetes when *medically necessary* and prescribed by a Physician, except as specifically described within the *Prescription* Drug section. Includes the installation and use of an insulin infusion pump, and diabetic self-management education programs. Insulin pump coverage is limited to the purchase of one pump per *calendar year.*

5. Blood and blood plasma.

a. Administration of blood and blood plasma including blood extracts or derivatives and a blood processing fee charged by a blood bank or blood center for up to six pints per *surgery*.

b. Intravenous therapy performed in the *participant's* home if prescribed by a Physician and pre-authorized by the *Plan Supervisor*.

6. Drugs and medicines. Those required by law to be obtained on the written *prescription* of a *qualified practitioner* when not rendered by a *pharmacy*.

7. Drugs for Treatment of HIV Infection. The *Plan* provides benefits to a *Participant* for *prescription* drugs for treatment of HIV infection in accordance with Section 632.895(9) of the Wisconsin Statutes. Drugs which satisfy all of the following are covered:

    1. Is prescribed by the *Participant*'s Physician for the treatment of HIV infection or any related condition arising from the HIV infection;

    2. Is approved by the Federal Food and Drug Administration for the treatment of HIV infection or related condition; and,

    3. If the drug is an *investigational* new drug, as provided in the statutes, is prescribed and administered according to approved protocol.

    Coverage of such drugs is subject to all *Plan* provisions that apply to all other *prescription* drug coverage.

8. Medical Supplies. When prescribed by *your* attending *physician* and approved as appropriate for treatment of the *plan participant's* disability. Examples of eligible types include, but are not limited to, the following:

    a. elastic stockings up to two pair per *Calendar Year* for 12-15 mm Hg compression (surgical weight) at the ankle or greater,

    b. catheters, suction catheters when respiratory-dependent; and catheters for intermittent bladder catheterization; and indwelling bladder catheters for documented neurogenic bladders. Coverage includes catheter insertion trays, catheter clamps, drainage tubing, bags and irrigation equipment,

    c. colostomy bags, rings and belts ostomy supplies required due to a colostomy or ileostomy,

    d. flotation pads,

    e. prosthetic bras up to three per *Calendar Year* due to mastectomy;

    f. other than disposable diabetic supplies such as needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips that are separately covered under the drug benefit of the *Plan*, and

    g. injectable forms of medication requiring a *prescription* and administered in an Outpatient setting by a *Qualified Practitioner* when appropriate.

9. Reconstructive *services*.
    a. Except as under item (b) of this provision, reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *Dependent child* which resulted in a functional defect.

    b. Reconstructive *services* following a covered mastectomy, including but not limited to:

1. reconstruction of the breast on which the mastectomy was performed;

2. reconstruction of the other breast to achieve symmetry;

3. prosthesis; and

4. treatment of physical complication of all states of the mastectomy, including lymphedemas.

10. Therapy *services*. Speech, occupational, physical, respiratory, radiation therapy and chemotherapy. Speech therapy limited to services for the correction or restoration of speech, voice or swallowing disorders from disease, trauma or surgery. Benefits may be available for additional therapy services if expected to result in significant physical improvement in your condition.

11. Cardiac rehabilitation. Limited to phases I and II.

12. Elective surgical reproductive sterilization (i.e., vasectomy and tubal ligation). Subject to all terms and provisions of the *Plan* except the exclusion for *services* which are not *medically necessary*.

13. Infertility. Benefits are provided for treatment up to the diagnosis of infertility only, including diagnostic testing and *services*.

14. Abortion. Procedure for the termination of a *participant's pregnancy* (including spontaneous, therapeutic and elective).

15. Lead Screening. Benefits are provided for blood lead tests for children under 6 years of age, according to screening protocols established by the Department of Health and Family Services.

16. Certified Nurse Midwives and Charges Made by a Free Standing *Birthing Center*.
A certified Nurse Midwife means a person who is; (1) licensed as such and acting within the scope of the license; and (2) acting under proper direction furnished in affiliation with a Free Standing *Birthing Center*, *Hospital* or other qualified alternate facility. Charges made by a Free Standing *Birthing Center* incurred by a person while the person's coverage is in force. All maternity related medical expenses made by a *Qualified Practitioner* at a *Hospital* or Free Standing *Birthing Center* or other qualified alternate facility. Benefits are payable as those for any other *illness*. Only one "facility" charge will be paid. For Example, if a *birthing center* is used and the mother is transferred to the *hospital*, only one facility fee will be paid in connection with the use of a midwife.

18. Birth Control Devices. If provided by written *prescription* or placement by your *physician*.

19. Autism: Charges for the cost of treatment for autism, Asperger Syndrome, and pervasive develop*mental disorder* are covered if the treatment is provided by a psychiatrist, psychologist, a social worker who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of any of those providers, or a professional working under the supervision of an outpatient mental health clinic. This coverage will be provided in accordance with all the terms and conditions of Wis. Stat. 632.895(12m) including the definition of a licensed provider, covered items, limitations, exclusions, applicable dollar limits, etc. Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.

20. *Morbid Obesity*. Effective for ATU Local #519 covered members only (see *exception for Non-ATU covered members below and Addendum K): *Surgery* related to treating *morbid obesity* is eligible only for a diagnosis of *morbid obesity* when all of the corresponding criteria apply:

    a. Non-surgical methods of weight loss have been supervised by a Physician within two years prior to the proposed *surgery* without success, as documented by a Physician who

does not perform bariatric *surgery*; History of failed non-surgical attempts at weight loss must include active participation in a structured and supervised weight loss program for a minimum of six months within the last two years. At least three of those months must be consecutive without gaps. There must be documentation in the medical records verifying this or verification by the provider of the weight loss program. This documentation must include weight data as well as documentation that diet, exercise and behavior modification information was addressed.

b. There is evidence of medical complications due to obesity;

c. There are no serious contraindications for *surgery* (*participant* is determined to be a good surgical candidate);

d. Body Mass Index (BMI) as defined as weight in kilograms, divided by height in meters squared of greater than 40 (>40). BMI >40 must have documentation of being present over at least a 2 year time frame (does not mean the BMI has to have been >40 for this whole time frame). BMI greater than 35 for a minimum of two years if one of more significant co-morbid conditions exist requiring ongoing medical management and which are likely to be improved or eliminated by obesity surgical treatment:

e. Age greater than 18

f. No evidence for untreated/uncontrolled mental health/AODA disease.

g. If approved, coverage is limited to one surgery per member's lifetime, regardless of payer. However, surgical revisions will be covered on a case by case basis as determined by the Plan Supervisor's Medical Management. Examples of revisonal procedures for complications include but are not limited to: gastrogastric fistulas (may manifest as weight regain); refractory or recurrent marginal ulcers; J-J intussusception; Roux-limb stasis and SMA syndrome. Revisions will not be covered for weigh regain or failed weight loss.

h. Documentation of willingness to comply with the preoperative and postoperative treatment plans.

All of the above criteria must be satisfied before benefits will be available. Prior written approval is recommended for *Morbid Obesity surgery*.

*Exception: Non-ATU members covered as of December 31, 2015 who have completed the required treatment plan (as defined above) as of December 31, 2015. Pre-authorization by the Plan Supervisor is required. If this requirement has been met and pre-authorization has been obtained, coverage for the covered member's morbid obesity surgery, as well as any follow-up care or care for surgical complications due to such surgery will be covered during the initial two months of 2016 only. Non-ATU covered members who had the surgery for morbid obesity prior to December 31, 2015, as a covered member, would be eligible for follow-up care coverage through the initial two months of 2016 only.

21. Approved Clinical Trial. Charges for a qualified Participant for routine costs of an Approved Clinical Trial when the routine costs would be a Covered Expense if provided outside of the Approved Clinical Trial. This excludes:

    a. The Investigational item, device or service itself.
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

A qualified individual is a Participant who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. The referring health care provider must conclude that the Participant's involvement in the clinical trial is appropriate or the Participant must provide information establishing why participation in the clinic trial is appropriate.

ALTERNATIVE CARE OR SERVICES

Additional *services* to those above may be covered when a Physician suggests an alternative course of treatment or *confinement* for which differs from that *plan participant's* current course of treatment or *confinement*. Upon written request from the Physician or *Qualified Practitioner*, the *Plan Supervisor* shall consider paying benefits under the *Plan* for charges for such treatment, *services* or supplies as long as such treatment, *services* or supplies:

1. are *Medically Necessary*;

2. the recommended alternate course of treatment or *confinement* offers a medical therapeutic value at least equal to the current treatment or *confinement*;

3. the current course of treatment or *confinement* may be changed without jeopardizing the *plan participant*'s health; and

4. the charges incurred for *services* to be provided under the alternative course of treatment or *confinement* will be less than those charges for treatment, *services* or supplies to be provided under the current course of treatment or *confinement* to its end.

The alternative care decision, if any, will be made on a case by case basis and does not set precedence for future claims.

Any alternative care decision must be approved by the *Plan Supervisor*, the attending Physician and the *plan participant* before that alternative course of treatment or *confinement* begins. Any additional treatment or *confinement* beyond the agreed to alternative course of treatment or *confinement* must be reviewed and reconsidered by the *Plan Supervisor* and approved by the *Plan Supervisor*, the attending Physician and the *plan participant*.

The *Plan Supervisor* will send a letter to the *plan participant* and his/her attending Physician. The letter will provide:

1. The alternative course of treatment or *confinement*;

2. The projected costs for such treatment or *confinement*; and

3. The benefits payable by the *Plan* for charges incurred for such course of treatment or *confinement*.

The benefits payable by the *Plan* will first be paid as otherwise provided under the *Plan*. In the event that the alternative course of treatment or *confinement* includes treatment, *services*, or supplies exceeding the fixed limits of days, service visits or visits under the *Plan*, the *Plan Supervisor*, at its option, will consider the payment of benefits under the *Plan* for charges for such treatment, *services* or supplies as long as such treatment, *services* or supplies are *Medically Necessary* to treat the *plan participant*. Payment of benefits, if any, shall be made as determined by the *Plan Supervisor*. This provision does not supersede or allow coverage for excluded types of *services* of the *Plan* or as stated in Section III – Limitations and Exclusions.

SECTION III - LIMITATIONS AND EXCLUSIONS

The *Plan* does not provide benefits for:

1. *Services*:

a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;

b. Not authorized or prescribed by a *qualified practitioner*;

c. Not covered by this *Plan* whether or not prescribed by a *qualified practitioner*;

d. Which are not provided;

e. Which are not *medically necessary* as determined by the *Plan (except as otherwise noted in the Schedule of Benefits);*

f. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this *Plan* unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or

g. Furnished by or payable under any *Plan* or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);

h. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;

i. For any person serving in the armed *services* of any country or organization; except to the extent coverage is required by Federal Law;

j. Performed in association with a service that is not covered under this *Plan*;

2. For the portion of the *services* for which a *Participant* is entitled to payment under *Medicare* Part A and B, provided *Medicare* is the *participant*'s primary payer.

3. *Services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically indicated in Other Covered Expenses; Keratorefractive eye *surgery* (such as tangential, radial or photorefractive keratotomy), laser surgeries for the correction of vision and implants, except to the extent the *Plan* provides coverage for refractive surgical procedures to improve vision for correction of refractive error resulting from prior *surgery* which cannot be corrected with lenses and for correction of congenital anisometropia which cannot be corrected with lenses; or vision therapy (orthoptics) are not covered;

4. For hearing aids, whether removable or surgically implanted, and the fitting or repair of hearing aids, except for children under the age of 18. See the *covered services* section for coverage of cochlear implants and hearing aids for children under the age of 18;

5. For medical *exams*, including eye and hearing *exams*, health assessments, procedures and associated *services* requested or directed by a third party including but not limited to: *exams* for insurance, employment, camp, or a court of law, except to the extent the *Plan* provides coverage for school-required physical *exams* (in place of the required annual *exam*);

6. *Services* related to gender change;

7. *Services* for a reversal of a surgical reproductive sterilization, or any related complications;

8. *Services* for alternative medical treatments or educational programs including, but not limited to, hypnotism, biofeedback, holistic medicine, acupuncture, massage therapy (except to the extent the *Plan* provides coverage performed by a Physician or Occupational Therapist), rolfing, health education, homeopathy, Reiki, and programs intending to provide complete person fulfillment or harmony;

9. *Services* for routine palliative or *cosmetic* foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except for capsular or bone *surgery*), calluses, toe nails (except for the complete removal of toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet except as specifically listed as covered;

10. Corrective shoes and orthotics, except when *medically necessary* or as otherwise specified;

11. Charges for the treatment, services, equipment and supplies resulting or arising from complications or incidental to any treatment, services, equipment or supplies not covered under the *Plan.*

12. Charges for *services* and supplies associated with the following causes including any complications:

a. which arises out of or in the course of employment with any *employer* who is eligible to obtain coverage under Workers' Compensation or Occupational Disease Law, or

b. for which the *plan participant* is eligible for benefits under any Workers' Compensation Law or Occupational Disease Law, or

c. for which the *plan participant* is paid a Workers' Compensation benefit or Occupational Disease Law Benefit, or

d. which arises out of, or in the course of, self-employment or other employment, regardless of whether such *plan participant* is actually covered by liability or Workers' Compensation insurance for such self-employment or other employment.

13. *Services* for *cosmetic surgery*. This exclusion does not apply if the *services* are required to correct a congenital birth defect(s) or developmental anomaly, to correct a deformity to restore bodily function following a disease or trauma or as allowed under the terms and conditions of the Women's Health Care Cancer Rights Act;

14. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar process, including but not limited to routine dental, orthodontics, or repair to a tooth injured by chewing, unless specifically provided under this *Plan in Section II*;

15. Any loss caused by or contributed to:

a. War or any act of war, whether declared or not; or

b. Any act of armed conflict, or than conflict involving armed forces of any authority;

c. Charges due to atomic or thermonuclear explosion or resulting radiation, revolt, taking part in a riot or civil disturbance;

16. Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, K, or PLA;

17. Any service which is *experimental, investigational or for research purposes*, unless specifically indicated in Other Covered Expenses. For example, any non-duplicated *services* that would standardly be covered under the *Plan* will continue to be covered. It is recommended that the *Plan Supervisor* review the paperwork for the clinical trial in advance of the treatment. The *Plan* excludes coverage for care, *services* or treatment required as a result of complications from a treatment not covered under the *Plan* (such as complications directly related to a clinical trial). Charges for *Experimental* procedures, drugs, or research studies, or for any *services* or supplies not considered legal in the United States or not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration. *Experimental* or *investigational services* include:

a. care, procedures, treatment protocol or technology which:
    i. is not widely accepted as safe, effective and appropriate for the *Injury* or *Sickness* throughout the recognized medical profession and established medical societies in the United States; or
    ii is Experimental, in the research or *investigational* stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies.

b. drugs, tests, and technology which:
    i. the FDA has not approved for general use;
    ii. are considered Experimental;
    iii. are for *investigational* use; or
    iv. are approved for a specific medical condition but are applied to another condition.

The *Plan* will rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human *Services*, and Congressional Office of Technology Assessment in determining *investigational* or *experimental services*.

18. Tobacco cessation products (covered under the Prescription Drug Benefit Plan);

19. Birth control drugs (covered under the *Prescription* Drug Benefit *Plan*);

20. Prenatal vitamins and *Prescription* Vitamins (covered only as specified under the *Prescription* Drug Benefit *Plan*);

21. Outpatient *Prescription* drugs for which coverage is available under the *Prescription* Drug Benefit;

22. For injection of a medication except as specifically provided;

23. *Custodial care* and *maintenance care*, except to the extent of coverage for *maintenance care* for out of *network* chiropractic *services* up to the *Plan*'s annual limits.

24. *Services* provided by a person who ordinarily resides in your home or who is a *family member*;

25. Charges in excess of the *maximum allowable fee* for the service;

26. Any *expense incurred* prior to your *effective date* under the *Plan* or after the date your coverage under the *Plan* terminates, except as specifically described in this *Plan*;

27. Any expense due to commission or attempt to commit a civil or criminal battery or felony; where person is charged and convicted, unless due to a medical condition, whether mental or physical;

28. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness (except for chiropractic care received on an Out-of-network basis);*

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

30. Expenses incurred for which *you* are entitled to receive benefits under *your* previous dental or medical *Plan* (unless otherwise stated under *Coordination of Benefits*);

31. All fertility testing or *services (other than diagnostic testing to the extent necessary to rule out a medical condition that would be covered),* including any artificial means to achieve *pregnancy* or ovulation, such as artificial insemination, in vivo fertilization, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), Peritoneal Oocyte Sperm Transfer (PROST), tubal ovum transfer, embryo freezing or transfer and sperm banking, similar procedures and other direct attempts to induce *pregnancy* or treat infertility, such as drug therapy or *surgery* related to infertility;

32. Allergy testing or immunotherapy unless such therapy or testing is approved by:

    a. the American Academy of Allergy and Immunology; or

    b. the Department of Health and Human *Services* or any of its offices or agencies;

33. *Services* for weight loss or control, body building, food received on an outpatient basis, special nutritional formulas, supplements or diets, unless for diagnosed *morbid obesity*. For diagnosed *morbid obesity*, the *Plan* allows coverage for limited *surgery* and drug coverage as outlined under the Other *Covered Services* section;

34. Services related to the treatment and/or diagnosis of sexual dysfunction/impotence, unless if due to *bodily injury* or *mental disorder* or another *sickness (or as covered under the prescription drug benefit)*;

35. Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments;

36. *Sickness* or *bodily injury* for which medical payments/personal *injury* protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *Plan* did not exist;

37. For inpatient *hospital* admissions primarily for X-ray and radiation therapy;

38. For Inpatient *hospital* admissions which are primarily for physical therapy, speech or occupational therapy;

39. Received from a dental or medical department maintained by or on behalf of an *employer* (other than the City of La Crosse), a mutual benefit association, labor union, trust or similar person or group;

40. For personal hygiene and convenience items such as but not limited to: adult incontinence garments; underpads; diaper service; blood pressure cuff or automatic blood pressure monitor; gloves; thermometers; alert or alarm devices; commode chair and related supplies; pressure or cushion pads and positioning cushions or wedges; heel or elbow

protectors heat lamps, pads or hot water bottles; bath, shower, or toilet chair or support devices; over-bed table or board; bed pans and urinals; patient lift, bathroom or toilet; safety equipment, belt, harness, vest, helmet, restraints; whirlpool, air conditioners, air cleaners, humidifiers, vaporizers; foot arch supports, orthopedic-type shoes, heel and pad inserts, shoe additions; batteries and chargers, vision aids, reachers, alternative communication devices and telephone or other alert devices or systems; physician's equipment; and equipment, models or devices with features not medically necessary for the *sickness* or *bodily injury* of the *Participant.*

41. For physical fitness items or exercise programs, except as specifically covered under the *Plan* for Cardiac rehabilitation phases I or II;

42. For telephone consultation charges, for failure to keep a scheduled visit, or charges for completion of a claim form or a return to work/school form;

43. Charges for marriage and sex counseling, behavior training, conduct disorders and related family counseling *(except as covered under the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease (ICD-9 CM) for marital maladjustment or parent-child problems);*

44. Charges for travel or accommodations, whether or not recommended by a *physician*, except for ambulance charges as defined as a covered expense;

45. Sleep Disorders: Care and treatment for sleep disorders, or sleep therapy related to sleep disorders of a non-organic origin or unless as deemed *medically necessary*. Refer to Durable Medical Equipment in the Other Covered Medical *Services* Section for additional details.

NOTE: If deemed *medically necessary*, pre-authorization is recommended for the rental or purchase of applicable durable medical equipment. Initial prior authorization for a CPAP/BIPAP machine, if approved, will be for one month. Follow up with the pulmonologist will be required for additional rental or for the rent-to-purchase option;

46. For the following genetic services, except as specified in Section II "Comprehensive Medical Benefits" herein.

a. Genetic counseling, studies and testing other than coverage that is expressly described above;

b. Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluation alone;

c. Genetic testing for conditions that cannot be altered by treatment or prevented by specific interventions.

d. Genetic testing solely for the purpose of informing the care or management of your family members or for the purpose of identifying a mutation that is for the benefit of a non-covered family member;

e. Genetic counseling performed by the laboratory that performed the genetic testing;

f. Genetic testing that is done for reproductive planning; and

g. Genetic testing that is not prior authorized, or that the Plan Supervisor considers experimental/investigational/unproven will not be covered. (NOTE: PRIOR AUTHORIZATION does not guarantee benefits if the testing or counseling performed is otherwise excluded, experimental, etc.).

47. Charges related to or in connection with a surrogate pregnancy, unless surrogate mother is a covered member under the Plan (see Pregnancy Benefits).

48. Charges while incarcerated in a penal institution or in legal custody;

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

50. Charges in relation to use of illegal drugs or medications;

51. Charges for *services* provided directly by an *employer* without charge to the *participant*;

52. Charges for educational, developmental or neuro-educational training, vocational training and work hardening *services*, recreational or educational therapy;

53. Charges related to routine immunization for lyme disease;

54. Charges related to gender determination such as, but not limited to, amniocentesis, chorionic villi sampling (CVS), and deoxyribonucleic acid (DNA);

55. Charges related to the rental or purchase of motor vehicles, lifts for wheelchairs and scooters, stair lifts, and other customization of vehicles;

56. Charges related to comprehensive pain management services (a coordinated, goal-oriented, interdisciplinary team *services* to reduce pain, improve functioning capacity and coping mechanisms of the patient, and decrease the dependence on the health care system for *participants* with chronic pain syndrome), except to the extent there is coverage under the *plan* for individual treatment modalities;

57. No benefits will be paid for biofeedback except to the extent the *Plan* provides coverage for headaches (migraine, muscular contraction, or vascular), spastic torticollis, back pain, myofascial pain, anal pain, and TMJ disorder;

58. No benefits will be paid for nutritional counseling except to the extent the *Plan* provides coverage for *morbid obesity*, cancer, diabetes, heart disease, high blood pressure, anorexia nervosa or bulimia or as required under law;

59. No benefits will be paid for charges related to whole organ transplants or artificial hearts, except to the extend the *Plan* provides coverage for initial human kidney, kidney/pancreas, corneal (keratoplasty), limited bone marrow applications, heart, heart/lung, liver, lung, musculoskeletal, and parathyroid transplants for recipients who are *plan participants*;

60. No benefits will be paid for services and supplies associated with the following conditions, including for low or declining physical or mental functioning compared to the normal range that may be due to conditions such as aging, gender, personal choices of lifestyle (such as poor exercise, poor diet, obesity other than *morbid obesity*), emotional or interpersonal conditions *(other than defined as mental illness).*

61. No benefits will be paid for services of a *Qualified Practitioner* who resides in the same household with a Participant, or who is related by blood, marriage, or legal adoption to the *Employee, Retiree* or his/her spouse.

SECTION IV - PRESCRIPTION DRUG BENEFITS

Outpatient *prescription* drug benefits are provided through a *prescription* drug program which has *co-payment* provisions that are separate from the medical benefits portion of the *Plan.* Drug benefits are payable subject to the Schedule of Benefits and the following provisions.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *qualified practitioner* for the treatment of a *sickness* or *bodily injury* or for *preventive care*; and

2. Be dispensed by a *pharmacist; and*

3. Be included in the drug *formulary* and;

4. Be approved by the U.S. Food and Drug Administration for general use throughout the country; and

5. Require the written *prescription* of a physician or *Qualified Practitioner* as permitted by law; and

6. Not have a comparable over-the-counter drug available.

Certain medications may require pre-authorization. Contact the *Prescription* Drug *Plan Supervisor* to determine if pre-authorization is required.

Drug *Formulary*. This means a list of preferred *prescription* drugs established to be clinically sound and cost effective by a committee of prescribers and *pharmacists* and selected for coverage under the *Plan*. The committee evaluates which *prescription* drugs to include and exclude from the *formulary* list based on effectiveness of the drug, side effects, drug interactions and cost. On-going evaluation of new and existing *prescription* drugs by the committee ensures the *formulary* is up to date and meets patient health needs.

Participating pharmacies. *Prescription* drugs are dispensed by using a drug card at a retail *pharmacy* or by mail service. The *Prescription* drug *Plan Supervisor* is identified on page 1 of this document. The drugs and supplies must be dispensed on or after the *participant*'s *effective date*, by a *Pharmacist*, for the outpatient use of the *participant*.

To obtain a *prescription you* must present *your* identification card to a *participating pharmacy* and pay *your co-payment.*

Step Therapy. Some drugs may be subject to Step Therapy in which lower cost alternative drugs must first be given a reasonable trial by the *plan participant*.

Mail-order service. A mail-order service is available under this *Plan* and is required to obtain certain maintenance medications. The mail order benefits of *your prescription* drug program are provided by the *Mail Order Service Provider* as identified on page 2 of this document. This mail service program provides *participants* with any easy and convenient way to obtain maintenance medications. A mail order kit that explains the mail service program in greater detail can be obtained by contacting the *Prescription* Drug *Plan Supervisor* at the phone number included on your benefit ID card.

When a maintenance medication is prescribed for a chronic medical condition, *you* are allowed an initial trial period at a retail *pharmacy* for up to two fills to confirm the dosage, compatibility and effectiveness. Thereafter, coverage for designated maintenance medications is limited to coverage under the mail-order benefit. A list of specific medications required to be obtained through mail order can be obtained from the *Prescription* Drug *Plan Supervisor* as identified on page 2 of this document.

When *your* doctor writes a *prescription* for a maintenance medication, ask him/her to write the order for up to a 90-day supply. The *pharmacy* by law can only fill *your prescription* with the quantity prescribed by

the physician.

Prescription drug management. This *Plan* manages *prescription* drug costs by providing coverage of *prescription* drugs through the use of a drug *formulary.* Ask *your* doctor to prescribe a *formulary* drug whenever possible. Non-*formulary* drugs are generally not covered. Coverage for non-*formulary* drugs may be approved via pre-authorization request in certain circumstances based on special patient needs.

Your co-payment for a *prescription* drug will be determined based on the Schedule of Benefits.

Covered benefits. Benefits are payable for covered *prescription* drugs, medicine or medication that are received by *you or your dependents* while covered under the *Plan*. The following are covered *prescription* drugs:

1. Federal *legend drug*s (which require a *prescription* under federal law) and for which over-the-counter or non-*prescription* drugs of comparable ingredients are not available.

2. State restricted drugs such as Schedule V. drugs (e.g., Lomotil, greater than 4 ounces of Robitussin with codeine, etc.) not to exceed a 30-day supply.

3. Compound drugs (with at least one federal *legend drug* ingredient).

4. Prenatal multi vitamins and *Prescription* vitamins *(as required by federal law*).

5. Retin-A for the treatment of significant acne to age 25 *(refer to prior authorization).*

6. Insulin; disposable insulin needles, lancets, syringes; and disposable blood, urine, pump supplies, swabs, glucose and acetone testing agents/test strips for diabetic management.

7. Contraceptives *(as required by federal law).*

8. Charges related to the treatment or diagnosis of sexual dysfunction/impotence related to organic disease or following *surgery*, limited to a maximum of 6 pills per month *(refer to prior authorization).*

9. Estrogen replacement and compound forms (e.g. Estring, Femring, Estrogel).

10. Effective 8/1/14, all Food and Drug Administration (FDA) approved tobacco cessation medications (including prescription and over-the-counter medications) for a 90 day treatment regimen (up to two attempts per year) when prescribed by a health care provider.

Limitations and exclusions for *prescription* drug benefits. Expenses incurred will not be payable for the following:

1. *Legend drug*s which are not recommended and not deemed necessary by a prescriber;

2. Non-*formulary* drugs, (except when pre-authorized based on special patient needs);

3. Therapeutic devices or appliances, including hypodermic needles, syringes, (except needles and syringes for diabetes), support garments, test reagents and other non-medical substances;

4. Injectable drugs (except as pre-authorized or unless otherwise stated). Injectable drugs, where covered, may require pre-authorization or be limited in quantity.

5. Anorectic or any drug used for the purpose of weight control, (except when pre-authorized);

6. Progesterone or hormones related to gender transformation in any compounded dosage form;

7. Dietaries, nutritional products, and vitamins;

8. Any drug used for *cosmetic* purposes, including, but not limited to minoxidil (Rogaine), photo

aged skin products, injectable *cosmetics* (Botox), depigmentation products used for skin conditions requiring a bleaching agent;

9. Tretinoin agents (e.g., Retin-A) used for *cosmetic* purposes except when pre-authorized for the treatment of significant acne when not responding to other forms of treatment;

10. Unit dose medication (individually packaged doses of a specific medication);

11. Fluoride preparations such as dental paste, gel, mouthwash or pediatric preparations (e.g., Luride, poly-Vi-Flor) except as required by law;

12. Non-*legend drug*s;

13. Fertility medications included but not limited to oral, vaginal and injectable fertility agents (e.g., Clomid, Crinone, ex Profasi, HCG, etc.);

14. Any drugs used to enhance performance and body building;

15. Replacement drugs (lost, stolen, damaged or destroyed) except when approved upon special appeal and not-to-exceed more than one per year.

16. Growth hormones (covered under medical benefits when *precertified* and *medically necessary);*

17. Vitamins and nutritional supplements included but not limited to: therapeutic agents used for specific deficiencies and conditions (e.g., Rocaltrol, Calciotriol, Niacin, Potaba), multivitamins (e.g., Nephrocaps, Vitacon Forte, Berocca), supplemental agents (e.g., Biotin), Hemopoetic agents such as for use treating anemia (e.g., Folic Acid, Niferex) *except as required by Federal law*;

18. Any drug for sexual dysfunction (other than related to organic disease or directly caused by prior allowable *surgery*;

19. Any drug for which a comparable over-the-counter drug is available (such as nutritional supplements) and when the FDA ends the status of requiring a *prescription* for a drug, except as required by Federal law;

20. All separately itemized fees for administration of a covered drug;

21. Any drug or medicine which is to be injected, taken, or administered, to *you or your* covered *dependents* by the prescriber;

22. Any drug or medicine which is to be taken, or administered, to *you or your* covered *dependent, while such person is confined in a qualified treatment facility* or dispensed at time of discharge*;*

23. Any drug labeled “Caution-limited by Federal Law to investigation use” or other wording having similar intent or *experimental* drugs or drugs with no established value even though a charge is made to *you* or *your* covered *dependent*s (other than specifically required by law for AIDS);

24. Any refill of a *prescription* drug which is in excess of what is prescribed, or any refill dispensed after one year from the initial *prescription* order;

25. Medication quantities exceeding the limitations established or the quantity limits except upon special appeal from the physician or *qualified practitioner* when determined to be medically appropriate under the standards of acceptable medical practice for the applicable condition and which is deemed to be *medically necessary*;

26. For *prescription* drugs:

    a. In a quantity which is in excess of a 30-day retail supply or 90-day supply if on the *Prescription* Drug *Plan Supervisor’s* Maintenance *Drug List*;

b. In a quantity which is in excess of amount prescribed; or

c. In a quantity which is in excess of the 90-day mail order supply;

27. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the *co-payment* amount in the absence of this benefit;

28. For drugs related to a non-covered benefit, service or diagnosis as identified in this *Plan*;

29. Any charge for the administration of a covered *Prescription* Drug.

30. Medications which require prior authorization under the terms of the Step Therapy program that have not been authorized by following the program guidelines, unless clinical authorization has been reviewed and approved based on review of medical history submitted by a physician;

31. Out-of-Network medications are excluded, except for:

    a. If an allowable special drug is NOT available from a *network pharmacy* and is therefore obtained out-of-network;

    b. If a drug is obtained in connection with *emergency* services when it is NOT reasonable to obtain from a *network pharmacy*.

    Such out-of-network claims must be paid by the *plan participant* at the point of service and then submitted by the *participant* to the *Prescription* Drug *Plan Supervisor* for reimbursement.

Other drug program provisions.

Contrary to any other provisions of the *Plan*, *prescription* drug expenses covered under the *prescription* drug benefit portion of this *Plan* are not covered under any other provisions of this *Plan*. Any drug expenses incurred under provisions of this section do not apply toward *your* medical *calendar year deductible* or out-of-pocket limits.

The drug *Plan supervisor* may decline coverage of a specific medication or, if applicable, *drug list* inclusion of any and all drugs, medicines or medication until reviewed and approved by the *Pharmacy* & Therapeutics subcommittee of the Pharmacy Benefit Manager following FDA approval for the use and release of the drug, medicine or medication into the market.

The Coordination of Benefits provisions of the *Plan* also apply to the *prescription* drug benefit. When dual coverage is in effect, *your dependent* is required to use the drug benefit of the primary insurer before submitting a drug claim under this *Plan.*

SECTION V - ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY

You are eligible to apply for coverage in this *Plan* if *you* are: employed by the City of La Crosse in a qualifying position, or if *you* are a qualifying *retired employee* of the City of La Crosse, subject to *City* Personnel Policy and/or any applicable collective bargaining agreement, Employee Handbook or defined within this Plan Document.

EFFECTIVE DATE OF COVERAGE – NEW EMPLOYEES

As a new *employee*, *You* shall become eligible for coverage effective on the first day of the calendar month following two (2) full calendar months as an *employee* provided *You* are in *active status* and/or employed on that date. *Note that if this results in a waiting period exceeding 90 days, such effective date shall revert to the 1st of the prior month, You* must submit the completed enrollment form to apply for either Individual, Limited Family or Family Coverage to the Plan Administrator within 31 calendar days of the initial eligibility date.

If *your* completed enrollment forms are received by the *Plan Administrator* more than 31 days after *your eligibility date*, *you* are a *late enrollee.* If *you* are declining enrollment for yourself or your *dependent*s and later wish to enroll without having a loss of other coverage, *you* would be a late enrollee and your *effective date* would be the first calendar day of the month succeeding sixty 60 days after the completed enrollment application is received by the Plan Administrator. *Note that if this results in a waiting period exceeding 90 days, such effective date shall revert to the 1st of the prior month,* See the "*Late Applicant*" paragraph of this Section V for more details. If *you* submit an enrollment form to the Plan Administrator beyond the 31 days, but qualify under the terms of a Special Enrollment, *you* will not be a *late enrollee*.

If *you* or *your dependent*s do not enroll in the *Plan* because *you* have medical coverage under another *plan*, *you* are required to sign a written waiver declining enrollment due to being covered under another *plan*.

A person that is reinstated as an *employee* within six months of the prior termination date as an *employee* would be eligible for coverage effective on the date of re-hire if classified as an *Employee* if a completed enrollment form is received within 31 days of the date of rehire.

<u>*Monthly Plan Contribution*.</u> The *employee* shall be responsible for payment of the *monthly plan contribution*, except as otherwise provided under this *Plan* Document, the terms of their applicable collective bargaining agreement, Employee Handbook and/or *City* Personnel Policies.

One Plan for Married Employees:
Married *employee*s of the City of La Crosse shall be limited to one medical benefit plan. The *Employee* with the most seniority shall be the holder of the *plan*. In the event that that coverage for the holder of the *plan* is terminated, the remaining *employee* shall become the holder of the *plan* and the former holder of the *plan* shall become the *dependent* without any waiting periods or limitations for *pre-existing conditions.*

DEPENDENT ELIGIBILITY

You may apply for Limited Family or Family Coverage to cover eligible *dependent(*s). An eligible *Dependent* means and includes any *dependent* which qualifies under any of the criteria outlined below:

<u>General *Dependent* Eligibility Criteria:</u>

1. The *Employee*'s or Retired *Employee*'s spouse based on a legal union as recognized by the State of Wisconsin.

2. The *Employee*'s or Retired *Employee's Child (*a natural *child*, step child, legally adopted *child*, or a *legal ward* of the *Employee* or *Retired Employee)* meeting one of the following criteria.

a. Pursuant to the terms and conditions of the Patient Protection and Affordable Care Act (PPACA) :

1. The *child* can be married or unmarried; and

2. The *child* must not yet have attained age 26.

b. An unmarried *child* over age 26 when determined by the *Plan Supervisor* to be incapable of self-sustaining employment by reason of total and permanent disability and *dependent* for at least 50% support (as specified by the Internal Revenue Service) from the *Employee* or Retired *Employee*.

Proof of total and permanent disability must be submitted to the *Plan Supervisor* within 31 calendar days of the date coverage would have ended due to the age limit of the *child*. Disabled *child* must have been covered under the *plan* on the day prior to the day coverage would have ended due to the age limit of the *child*.

3. A *child* for whom a *Qualified Medical Child Support Order* (QMCSO) has been issued in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA-93) or a Qualified Domestic Relations Order (QDRO).

4. The *child* of a covered *Dependent child* (grandchild of *Employee* or Retired *Employee*) only if *Dependent child* is covered under the *Plan* and only until the *Dependent child* is 18 years of age.

In no event shall the term *Dependent* include an *Employee*'s or *Retired Employee's* spouse or *child* who is:

a. Covered under the *Plan* as an *Employee*;
b. Covered under the *Plan* as a *Dependent* of another *Employee* under the *Plan*;
c. Not a permanent legal resident of the United States;
d. A relative not specified above; or
e. No longer the legal *Dependent* of the *Employee* or spouse as the result of termination of parental rights;

The *Employee or Retired Employee* may enroll *dependent*s only if the E*mployee* or *Retired Employee* is also enrolled. Check with the Plan Administrator immediately on how to enroll for *dependent* coverage.

A *Dependent child* who ceases to be an eligible *Dependent* shall be eligible for continuation of coverage rights in accordance with State or Federal Law.

Military Service Extension: A *dependent* may also qualify for coverage if they satisfy all of the following criteria:

1. The *child* is not married; and

2. The *child* is under age 27; and

3. The *child* is a full-time student at the time they were called to federal active military service duty in the National Guard or in a reserve component of the U.S. armed forces.

If the three criteria above have been satisfied, *dependent*s returning from federal active military duty can be reinstated (regardless of age) if they were a full-time student before military service and they re-enroll as a full-time student at an institution of higher education within 12 months after completing active duty to apply for full time student status at an institution of higher education.

RETIREE ELIGIBILITY

For ATU; Subject to your applicable collective bargaining agreement, for all others per the following with detailed criteria found in Addendums A, B, C and D contained within this Plan Document: *employee*s and their eligible *dependents* are eligible to remain in the *Plan* at retirement as outlined below:

1. The *Employee* must be covered under the *Plan* on the day immediately prior to becoming a Retired *Employee*; and

2. The *Employee* must retire under the Wisconsin Retirement System (WRS) on the basis of age, duty or non-duty related disability or be receiving long term disability income as defined in this Plan Document in Addendum A, B, C or D, in the *employee*'s applicable collective bargaining agreement or Employee Handbook; and

3. The *Employee* must have been hired full time prior to 7/1/13 or 1/1/14 as specified in the respective collective bargaining agreement, Employee Handbook or within this Plan Document in Addendum A, B or D.

4. The *Employee* must meet length of service requirements as contained in his/her applicable collective bargaining agreement, Employee Handbook or defined within this Plan Document Addendum A or B; and

5. The *Employee* must not be otherwise eligible to enroll in *MEDICARE* on the basis of age.

6. The *Dependent* must continue to meet *Dependent* eligibility requirements as outlined in the *Plan*.

The following restrictions apply to *retiree* eligibility:

1. Changes in coverage. Any changes in coverage shall be subject to qualifying events as defined under the *plan* document or HIPAA regulations.

2. Late enrollment permitted. An otherwise eligible *Retired Employee* who elected to continue under the *Plan* at retirement but later elects to terminate coverage may enroll again under Special Enrollment or *Late Applicant* provisions of this document until such time *Retired Employee* no longer meets *Retired Employee* eligibility criteria.

3. *Monthly Plan Contribution*. The *retiree* shall be responsible for payment of the *monthly plan contribution* by the established due date, except as otherwise provided under this *Plan* Document, the terms of their applicable collective bargaining agreement, Employee Handbook and/or *City* Personnel Policies.

4. One *Plan* for Married *Retiree*/*Employee*. If an eligible *Employee* and *Retired Employee* are married, they shall be limited to one limited family/family *plan*.

SURVIVING SPOUSE/DEPENDENT ELIGIBILITY & EFFECTIVE DATE

Subject to applicable collective bargaining agreements, Employee Handbook, defined within this Plan Document Addendum H & I and/or *City* Personnel Policies, the surviving spouse and/or eligible *dependent*(s) of a covered *Employee* or *Retired Employee* (who dies before he/she becomes eligible for *Medicare*) shall be eligible for coverage under the *Plan* as outlined below. *Effective date* of coverage shall be the first calendar day following the *Employee* or Retired *Employee*'s date of death. Such surviving spouse and/or *dependent*(s) must complete and submit an enrollment form to the Plan Administrator within 31 calendar days of the *Employee* or Retired *Employee*'s date of death. Failure to submit an enrollment within the required deadline would result in the surviving spouse and/or *dependent*s becoming a *Late Applicant* and the *effective date* of coverage would be delayed.

Surviving spouse.

a. must be covered under the *Plan* on the date of death of the covered *Employee* or Retired *Employee*; and
b. must remain unmarried; and
c. must not be eligible to enroll under *Medicare* on his or her own earnings record or through a *family member*.

Surviving *Dependent*s.

a. must be covered under the *Plan* on the date of death of the covered *Employee* or Retired *Employee*; and
b. must meet eligibility criteria under *Dependent* guidelines; and
c. must not be eligible to enroll under *Medicare* on the basis of age or disability.

A *child* born within ten months after the death of an *employee* or *retired employee* for which parenthood has been legally established may enroll as a surviving *dependent* as long as they otherwise meet the definition of eligible *dependent,* the *child* is not eligible to enroll under *Medicare, and such child is enrolled within 31 days following the date of birth*.

Monthly Plan Contribution. The *surviving spouse or dependent* shall be responsible for payment of the *monthly plan contribution*, except as otherwise provided under this *Plan* Document, the terms of their applicable collective bargaining agreement, Employee Handbook and/or *City* Personnel Policies.

Late enrollment permitted. An otherwise eligible Surviving Spouse and/or *Dependent* who enrolled when first eligible (i.e. date of death) but later elects to terminate coverage may enroll again under Special Enrollment or *Late Applicant* provisions of this document until such time the Surviving Spouse and/or *Dependent*s no longer meet eligibility criteria.

This coverage is in addition to and separate from continuation of coverage under *COBRA*.

YOUNGER SPOUSE ELIGIBILITY & EFFECTIVE DATE

Subject to applicable collective bargaining agreements, Employee Handbook, defined within this Plan Document (Addendum E), and/or *City* Personnel Policies, the younger spouse and *dependent*s of a covered *Retired Employee* whose coverage terminates due to the covered Retired *Employee*'s eligibility for *Medicare* shall be eligible for continued coverage under the *Plan*. Such younger spouse and *dependent*s must be covered under the *Plan* on the on the day preceding the Covered *Retired Employee* becoming eligible for *Medicare*.

Such younger spouse must complete and submit an enrollment form to the Plan Administrator within 31 calendar days of the Retired *Employee*'s *Medicare eligibility date*.

Monthly Plan Cost. The younger spouse shall be responsible for payment of the *monthly plan cost* by the established due date, except as otherwise provided under this *Plan* Document, the terms of their applicable collective bargaining agreement, Employee Handbook and/or *City* Personnel Policies.

Late enrollment not permitted. A younger spouse that does not enroll in coverage when first eligible or who elects coverage and thereafter fails to maintain coverage under the *Plan* forfeits any rights to coverage under this provision, i.e. the late enrollment and/or Special enrollment provisions will not apply.

This coverage is in addition to and separate from continuation of coverage under *COBRA*.

LATE APPLICANT/ENROLLEE

A *late applicant* is any eligible *Employee*, Retired *Employee*, Surviving Spouse/Surviving *Dependent* or General *Dependent* who does not enroll for coverage within 31 days of initial eligibility, who subsequently elects to enroll in the *Plan* and who does not meet the provisions under Special Enrollment. *Effective date* of coverage would be the first calendar day of the month following sixty (60) days after a completed enrollment form is received by the Plan Administrator along with payment of applicable required *monthly plan contribution*. *Note that if this results in a waiting period exceeding 90 days, such effective date shall revert to the 1st of the prior month,*

Monthly Plan Contribution. The *late applicant* shall be responsible for payment of the *monthly plan contribution*, except as otherwise provided under this *Plan* Document, the terms of their applicable collective bargaining agreement, Employee Handbook and/or *City* Personnel Policies.

SPECIAL PROVISIONS FOR NOT BEING IN *ACTIVE STATUS*

The following is subject to applicable current collective bargaining agreements, Employee Handbook, as defined within this Plan Document and/or *City* Personnel Policies,

a) Coverage will remain in effect for an *Employee* on an approved leave of Absence without pay (non-FMLA) up to a maximum of the duration of the leave or 30 calendar days, whichever occurs first. This provision is available one time during a rolling twelve month period.

b) Coverage will remain in effect for an *Employee* who is receiving the Income Continuation Insurance (ICI) benefit and who meets the minimum number of years of continuous service as defined in the applicable collective bargaining agreement, Employee Handbook or within this Plan Document (Addendum C) until whichever of the following occurs first:
    1. the *Employee* becomes eligible for a Wisconsin Retirement System benefit of any kind (i.e. normal retirement pension, disability pension or Long Term Disability Insurance benefit), or
    2. *Medicare* or Medicaid, or
    3. A period of one year while on ICI.

In either of the above situations, the *Employee* must pay the required *monthly plan contribution*. If not paid, coverage under the *Plan* may, with notice to the *Employee*, be terminated.

REINSTATEMENT OF COVERAGE FOLLOWING IN*ACTIVE STATUS*

If your coverage under the *Plan* was terminated due to your inactive status, and *you* are now returning to work, your coverage will be reinstated effective immediately on the day *you* return to work. Eligibility waiting periods and preexisting condition limitations will be imposed only to the extent they were applicable prior to your *inactive status*. Any accumulated *calendar year* maximums will apply.

If your coverage under the *Plan* was terminated due to a period of service in the uniformed *services* covered under the Uniformed *Services* Employment and Reemployment Rights Act of 1994 (USERRA), your coverage is effective upon the day succeeding the last day that the insurance provided by the U.S. government was in effect when: a) when the application is received within 31 days after this qualifying event, and b) payment is made of any required monthly *contributions*. Eligibility waiting periods and preexisting condition limitations will be imposed only to the extent they were applicable prior to the period of service in the uniformed *services*. Any accumulated *calendar year* maximums will apply.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Regardless of the established leave policies mentioned elsewhere in this document, this *Plan* shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

If *you* are granted a leave of absence as required by the Federal Family and Medical Leave Act (FMLA), *you* may continue to be covered under the *Plan* for the duration of the leave under the same conditions as other *employee*s who are in *active status* and covered by the *Plan*. If *you* choose to terminate coverage during the FMLA leave, or if coverage terminates as a result of your nonpayment of any required *contribution*, coverage may be reinstated on the date *you* return to *active status* immediately following the end of the FMLA leave. Charges incurred after the date of reinstatement will be paid as if *you* had been continuously covered.

Employee eligibility requirements, the obligations of the *Employer* and *Employee* concerning conditions of qualified FMLA leave, and notification and reporting requirements are specified in the FMLA. Any *plan* provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A *plan participant* with questions concerning any rights and/or obligations should contact the *Plan Administrator*.

SPECIAL ENROLLMENT PERIODS DUE TO QUALIFYING EVENTS

1. If *you* declined enrollment for yourself and/or your eligible *dependent*s because of other health insurance or group coverage, *you* would be able to enroll yourself and your eligible *dependent*s in this *Plan* if:

    a. *You or your* eligible *dependent*(s) voluntarily or involuntarily lose that other coverage or the period of *COBRA* continuation there from, and

    b. *You* submit a completed enrollment form to the Plan Administrator within 31 days (or 60 days as indicated below for loss of coverage through Medicaid or CHIP) after the loss of the other coverage. Coverage would be effective the day following the date coverage was lost.

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

2. If *you* have a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, *you* may be able to enroll yourself and your *dependent*s if:

a. *You* submit a completed enrollment form to the Plan Administrator within 31 days after the marriage, birth, adoption, or placement for adoption. The *effective date* would be the date of the event (marriage, birth, adoption or placement for adoption).

3. If *you* (and your applicable *dependent*s) lose coverage under the *Plan* due to the your active duty in the U.S. Armed Services (and subsequently were covered under insurance provided by the U.S. Government) thereafter returns to being an *Employee* after honorable discharge from the active duty, *you* would be able to enroll yourself and your eligible *dependent*s in the *Plan* (as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if:

    a. *You* submit a completed enrollment form to the Plan Administrator within 31 days after the last day that the insurance provided by the U.S. government was in effect.

    b. Coverage would be effective the day succeeding the last day that the insurance provided by the U.S. government was in effective.

For the above qualifying events, failure to enroll within 31 days would result in *you* and/or your *dependent*s being a *Late Applicant*. Please see *Late Applicant* Section.

PRE-EXISTING CONDITIONS

Per the Patient Protection and Affordable Care Act (PPACA), effective January 1, 2014, waiting periods for pre-existing conditions do not apply.

SECTION VI - TERMINATION AND CONTINUATION

TERMINATION OF COVERAGE

A *plan participant'*s coverage under the *Plan* will terminate on the earliest of the following dates, except as provided under "Continuation of Health Coverage".

1. the date the *Plan* is terminated or with respect to any *participant* benefit of the *Plan*, the date of termination of such benefit;

2. the last day of the calendar month in which the *Employee*'s employment with the *City* is terminated,

3. the last day of the calendar month in which the *Employee* ceases to qualify as an *Employee* eligible for coverage for any reason including reduction of hours to below the minimum required for eligibility (except as otherwise stated below);

4. the last day of the calendar month in which the *Dependent* no longer meets the eligibility requirements, except as otherwise provided in the Eligibility and *Effective Date*s section;

5. the last day of the calendar month following the month in which the *Employee* enters active military service, except for temporary duty of 31 calendar days or less (or as required under USERRA). Note that this termination does NOT apply to the two (2) week training of reserves or National Guard and any period longer than 31 days as may be required by law for a special period of general call-up to active duty necessitated by armed conflict;

6. the last day of the calendar month following the day in which the *dependent* enters active military service except for temporary duty of 31 calendar days or less (or as required under USERRA). Note that this termination does NOT apply to the two (2) week training of reserves or National Guard and any period longer than 31 days as may be required by law for a special period of general call-up to active duty necessitated by armed conflict;

7. the last day prior to the day that a *plan participant* is determined by the *City* to have made false, misleading or incomplete statements by or on behalf of a *plan participant* regarding a claim or eligibility for the *Plan*. This includes intentional failure to timely report material changes in status that impact eligibility;

8. the day preceding the day when a *Retired Employee* or Surviving Spouse becomes eligible to enroll for *Medicare* on his or her own earnings record or through a *family member* on the basis of age; Note: Surviving Spouses coverage may terminate prior to this per the applicable collective bargaining agreement, Employee Handbook, as defined within this Plan Document or Personnel Policy.

9. the day preceding the day when a covered disabled *dependent* becomes eligible to enroll for *Medicare* on the basis of age on his or her own earnings record or through a *family member* and the *Employee* or *Retired Employee* is terminated from regular coverage under the *Plan* on or before such date.

10. the last day for which the *Employee* or *Retired Employee was alive, in the event of their death.* An eligible spouse and/or *dependent*s may be eligible to continue if application is made in accordance with the surviving spouse and/or *dependent* provisions (where applicable; See "Surviving Spouse/*Dependent* Eligibility & *Effective Date* "in Section V);

11. the last day of the calendar month in which a surviving spouse who is covered under the *plan* is married;

12. the end of the month in when a surviving *dependent* becomes eligible to enroll in *Medicare* on the basis of total disability or age on his or her own earnings record or through a *family member*.

13. for a *dependent child*, the last day of the month preceding the day the *Retired Employee* or Younger Spouse is terminated from the *Plan* due to becoming eligible to enroll in *Medicare* on the basis of age on his or her own earnings record or through a *family member*.

14. the last day of the calendar month in which the *Employee* failed to return to *active status* as an *employee* when an approved leave of absence (of up to 30 calendar days) terminates;

15. the last day of the calendar month for which the last required *plan contribution* was made by the *Employee, Retired Employee, Younger Spouse, or Surviving Spouse or Dependent* in the event the monthly *contribution* is not paid timely.

16. the last day of the calendar month following the *Employee* or *Retired Employee* makes a request to terminate coverage;

If your *contributions* were taken on a pre-tax basis and *you* wish to terminate coverage during the year, but do not have a qualifying change in status in accordance with IRS regulations, *you* will continue to pay your pre-tax *contributions* until the end of the *plan year*. If *you* wish to have your *contributions* taken on an after-tax basis, please contact the Human Resources Department for a Pre-Tax *Contribution* Waiver form.

No benefits are available to a *plan participant* for *covered services* rendered after the date of termination of the *plan participant's* coverage, except as continued through *COBRA* "Continuation of Coverage".

IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

Federal law may affect your coverage under this *Plan*. The *Medicare* as Secondary Payer rules *were* enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health *plan* provides coverage to *employee*s (or their spouses) over age 65 *were* added to the Social Security Act and the Internal Revenue Code.

Generally, the health care *plan* of an *employer* that has at least 20 *employee*s must operate in compliance with these rules in providing *plan* coverage to *plan participants* who have "current employment status" and are *Medicare* beneficiaries, age 65 and over.

Persons who have "current employment status" with an *employer* are generally *employee*s who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an *employer* for up to 6 months; or
- Individuals who retain employment rights and have not been terminated by the *employer* and for whom the *employer* continues to provide coverage under this *Plan* (for example, *employee*s who are on an approved leave of absence).

If *you* are a person having "current employment status" who is age 65 and over (or the *dependent* spouse age 65 and over of an *employee* of any age), your coverage under this *Plan* will be provided on the same terms and conditions as are applicable to *employee*s (or *dependent* spouses) who are under the age of 65. Your rights under this *Plan* do not change because *you* (or your *dependent* spouse) are eligible for *Medicare* coverage on the basis of age, as long as *you* have "current employment status: with your *employer*.

You have the option to reject *plan* coverage offered by your *employer*, as does any eligible *employee*. If *you* reject coverage under your *employer*'s *Plan*, coverage is terminated and your *employer* is not permitted to offer *you* coverage that supplements *Medicare covered services*.

If *you* (or *your dependent* spouse) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this *Plan* will consider its coverage to be primary to *Medicare* when *you* have elected coverage under this *Plan* and have "current employment status".

If *you* have any questions how coverage under this *Plan* relates to *Medicare* coverage, please contact your *employer*.

CONTINUATION OF MEDICAL BENEFITS (*COBRA*)
THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986

CONTINUATION COVERAGE RIGHTS UNDER *COBRA*
Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (*COBRA*), certain *Employee*s and their families covered under the City of La Crosse Plan (the *Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called "*COBRA* continuation coverage") where coverage under the *Plan* would otherwise end. This notice is intended to inform *Plan Participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of *COBRA*, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is the City of La Crosse Human Resources Department, 400 La Crosse Street, La Crosse, WI 54601-3396, (Phone (608) 789-7595). *COBRA* continuation coverage for the *Plan* is administered by the City of La Crosse Human Resources Department, 400 La Crosse Street, La Crosse, WI 54601-3396, (Phone (608) 789-7595). Complete instructions on *COBRA*, as well as election forms and other information, will be provided by the Plan Administrator to *Plan Participants* who become Qualified Beneficiaries under *COBRA*.

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

Who can become a Qualified *Beneficiary*? In general, a Qualified *Beneficiary* can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a *Plan* by virtue of being on that day either a covered *Employee*, the Spouse of a covered *Employee*, or a *Dependent child* of a covered *Employee*. If, however, an individual is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a Qualified *Beneficiary* if that individual experiences a Qualifying Event.

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

The term "covered *Employee*" includes not only common-law *employee*s (whether part-time or *full-time*) but also any individual who is provided coverage under the *Plan* due to his or her performance of *services* for the *employer* sponsoring the *Plan* (e.g., self-employed individuals, in*dependent* contractor, or corporate director).

An individual is not a Qualified *Beneficiary* if the individual's status as a covered *Employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *Employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified *Beneficiary*, then a Spouse or *Dependent* child of the

individual will also not be considered a Qualified *Beneficiary* by virtue of the relationship to the individual. A domestic partner is not a Qualified *Beneficiary*.

Each Qualified *Beneficiary* (including a *child* who is born to or placed for adoption with a covered *Employee* during a period of *COBRA* continuation coverage) must be offered the opportunity to make an in*dependent* election to receive *COBRA* continuation coverage.

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

1. The death of a covered *Employee*.

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

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

4. A covered *Employee*'s enrollment in any part of the *Medicare* program.

5. A *Dependent child*'s ceasing to satisfy the *Plan*'*s* requirements for a *Dependent child* (for example, attainment of the maximum age for dependency under the *Plan*).

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

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

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

What is the election period and how long must it last? The election period is the time period within which the Qualified *Beneficiary* can elect *COBRA* continuation coverage under the *Plan*. The election period must begin not later than the date the Qualified *Beneficiary* would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified *Beneficiary* would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified *Beneficiary* of her or his right to elect *COBRA* continuation coverage.

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

Is a covered *Employee* or Qualified *Beneficiary* responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The *Plan* will offer *COBRA* continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The *employer* (if the *employer* is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the *employee*,
3. commencement of a proceeding in bankruptcy with respect to the *employer*, or
4. enrollment of the *employee* in any part of *Medicare*.

IMPORTANT:

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

NOTICE PROCEDURES:

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

City of La Crosse Human Resources
400 La Crosse Street
La Crosse, Wisconsin 54601-3396
(608)789-7595 phone
(608)789-7598 fax

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

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

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

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

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, *COBRA* continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified *Beneficiary* will have an in*dependent* right to elect *COBRA* continuation coverage. Covered *employee*s may elect *COBRA* continuation coverage for their spouses, and parents may elect *COBRA* continuation coverage on behalf of their children. For each Qualified *Beneficiary* who elects *COBRA* continuation coverage, *COBRA* continuation coverage will begin on the date that plan coverage would otherwise have been lost (e.g., at the end of the month). If *you or your* spouse or *dependent* children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the *Plan* with respect to the Qualified *Beneficiary*.

3. The date upon which the *Employer* ceases to provide any group health plan (including a successor plan) to any *employee*.

4. The date, after the date of the election, that the Qualified *Beneficiary* first becomes covered under any other *Plan* that does not contain any exclusion or limitation with respect to any *pre-existing condition*, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified *Beneficiary*.

5. The date, after the date of the election, which the Qualified *Beneficiary* first enrolls in the *Medicare* program (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified *Beneficiary* entitled to a disability extension, the later of:

    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified *Beneficiary* whose disability resulted in the Qualified *Beneficiary's* entitlement to the disability extension is no longer disabled, whichever is earlier; or

    b. the end of the maximum coverage period that applies to the Qualified *Beneficiary* without regard to the disability extension.

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

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

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

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

2. In the case of a covered *Employee*'s enrollment in the *Medicare* program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered *Employee* ends on the later of:

    a. 36 months after the date the covered *Employee* becomes enrolled in the *Medicare* program; or

    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered *Employee*'s termination of employment or reduction of hours of employment.

3. In the case of a Qualified *Beneficiary* who is a *child* born to or placed for adoption with a covered *Employee* during a period of *COBRA* continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of *COBRA* continuation coverage during which the *child* was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

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

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

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

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

What is Timely Payment for payment for *COBRA* continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the *Plan* by a later date is also considered Timely Payment if either under the terms of the *Plan*, covered *employee*s or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the *Employer* and the entity that provides *Plan* benefits on the *Employer*'s behalf, the *Employer* is allowed until that later date to pay for coverage of similarly situated non-*COBRA* beneficiaries for the period.

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

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

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

IF YOU HAVE QUESTIONS
If *you* have questions about *your COBRA* continuation coverage, *you* should contact the *COBRA* Administrator or *you* may contact the nearest Regional or District Office of the U.S. Department of Labor's *Employee* Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect *your* family's rights, *you* should keep the Plan Administrator informed of any changes in the addresses of *family member*s. *You* should also keep a copy, for *your* records, of any notices *you* send to the Plan Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA) AND *COBRA*

The *City* must maintain coverage under this *Plan* for covered *employees* who are on an approved leave under the Family and Medical Leave Act (FMLA) at the same level of coverage and under the same conditions as though the *employee* was actively working (including requiring the *Employee* to pay his/her portion of the monthly *contribution* during the FMLA leave). If an *Employee* takes FMLA leave and then decides not to return to work, the qualifying event will occur when the *employee* informs the *City* of the intent to terminate. In addition, the *Employee* is entitled to *COBRA* coverage even if he/she had a lapse in coverage during FMLA leave because of the *Employee*'s failure to pay the *employee* portion of the monthly *contribution* during the FMLA leave.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT ACT (USERRA)

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

1. The maximum period of coverage of a person under such an election shall be the lesser of:

    - The 24 month period beginning on the date on which the person's absence begins; or

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

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

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

SECTION VII - COORDINATION OF BENEFITS (COB) AND SUBROGATION

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the *plan participant* who is covered by this *Plan* is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This *Plan* will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan or plans will not exceed 100% of allowable expenses. Only the amount paid by the *Plan* will be charged against the *Plan* maximums.

When the *City Plan* is the Secondary *Plan*, it shall credit back to a *plan participant* any copay and/or co-insurance amounts applied per service encounter and annual *deductible* amounts it would have applied and charged during a year against the amount due for such *plan participant* during such year in the absence of another coordinating plan. Any amount initially saved by the *City Plan* for a *plan participant* (other than plan savings related to drug benefits) is accumulated in a COB credit account for such *plan participant*. When such credit amounts exist and a claim service line is processed where the allowable expense is not met by the combined benefits of other coordinating plans, the unpaid amount is taken from such credit savings of the *plan participant* and is used to pay up to the allowable expense not otherwise payable – common copay amounts applied per service encounter, co-insurance, annual *deductible* amount, and copay percentage amounts.

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

DEFINITIONS

The term "plan" as used herein will mean any plan providing benefits or *services* for or by reason of medical, vision, or dental treatment, except that a voluntary dental insurance plan offered to *employee*s shall be considered secondary for any types of *services* otherwise eligible under both of such plans, and any other dental plan shall be primary to this *Plan*. In this section, the term plan includes such benefits or *services* are provided by:

1. Group insurance or any other arrangement for coverage for *plan participants* in a group whether on an insured or uninsured basis, including but not limited to:

    a. *Hospital* indemnity benefits.

    b. *Hospital* reimbursement-type plans which permit the *plan participants* to elect indemnity at the time of claims.

2. *Hospital* or medical service organizations on a group basis, group practice, group service plans and other group pre-payment plans.

3. *Hospital* or medical service organizations on an individual basis having a provision similar in effect to this provision.

4. A licensed Health Maintenance Organization (H.M.O.).

5. Any coverage for students which is sponsored by or provided through a school or other educational institution.

6. Any coverage under a governmental program and any coverage required or provided by any statute.

7. Group automobile insurance.

8. Individual automobile insurance coverage on an automobile leased or owned by the *City*.

9. Individual automobile insurance coverage based upon the principles of "No-Fault" and/or Personal *Injury* Protection coverage.

10. Medical payment coverage under any group or individual automobile policy.

11. Any coverage under labor-management trusted plans, union welfare plans, *employer* organization plans or *employee* benefit organization plans.

12. Closed healthcare provider panel or exclusive healthcare provider plans.

13. Medical care components of long term care contracts such as skilled nursing care.

14. Any other insured or self-insured group plans.

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

The term "**allowable expenses**" means any necessary item of expense, the charge for which is reasonable, regular, and customary, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of *services* rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

The following are examples of expenses that are not an allowable expense:

1. An expense that is not covered by any coordinating plan is not an allowable expense.

2. Any expense that a healthcare provider by law or in accordance with a contractual agreement is prohibited from charging a *plan participant* is not an allowable expense.

3. If a person is covered by two or more “Coordinating Plans” that compute their benefit payments on the basis of prevailing fee level, *usual and customary* fees, or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

4. If a person is covered by two or more “Coordinating Plans” that provide benefits or *services* on the basis of fees negotiated with healthcare providers, an amount in excess of the highest of the negotiated fees is not an allowable expense.

5. The amount of any benefit reduction by the Primary Plan because a *plan participant* has failed to comply with the Primary Plan’s provisions is not an allowable expense. Examples are included but not limited to second surgical opinion requirements, *precertification* requirements, *Network* requirements, etc.

6. If a coordinating plan is advised that a *plan participant* is also covered under a high *deductible* health plan (determined to be the Primary Plan) and intends to contribute to a health savings account (HSA) established in accordance with section 223 of the Internal Revenue Code of 1986, such primary high *deductible* health plan’s *deductible* is not an allowable expense, except for any health care *expense incurred* that may not be subject to the *deductible* as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.

7. In the case of HMO (Health Maintenance Organization) or other in-network-only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the Covered Person does not use an HMO or *network* provider, this *Plan* will not consider as an allowable

charge any charge that would have been covered by the HMO or *network plan* had the Covered Person used the *services* of an HMO or *network* provider.

8. If a person is determined to be covered under the *Plan* as the “Secondary Coordinating Plan” for drug benefits, then:

    a. Any amount in excess of the of the negotiated fee discounts under the *Plan* is not an allowable expense.
    b. Any amount provided by a *pharmacy* or provider not participating in the *pharmacy network* of the *Plan* is not an allowable expense.
    c. Any amount for a drug requiring prior authorization and step therapy is not an allowable expense unless approved by the *Pharmacy* Benefit Manager as meeting the prior authorization and step therapy requirements.
    d. Any amount for a drug not listed in the *formulary* of the *Plan* is not an allowable expense unless otherwise approved by the *Pharmacy* Benefit Manager as meeting such *formulary* requirements.
    e. Any amount in excess of the limits on quantity per month or duration of monthly supplies is not an allowable expense.
    f. Any amount for a drug excluded from the *Plan* as having an over-the-counter or non-*prescription* alternative is not an allowable expense.
    g. Any amount for a drug specifically excluded by name, class, type, or diagnosis from the *Plan* is not an allowable expense.

The term "**claim determination period**" means a *Calendar Year* or that portion of a *Calendar Year* during which the Covered Person for whom claim is made has been covered under this *Plan*.

ORDER OF BENEFIT DETERMINATION RULES

When a *participant* has health care coverage under more than one *plan*, this *Plan* makes its claim payment according to where it falls in this order, if *Medicare* is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans

2. This *Plan* shall be “secondary” in coverage to any no fault or personal *injury* automobile insurance policy or coverage, regardless of any election made to the contrary by a covered *Plan participant*. Any available no-fault insurance shall be the “primary” coverage for any health care bills incurred as a result of any auto accident.

3. Non-*dependent*/*Dependent*. The benefits of the *plan* which covers the person as an *employee* are determined before those of the *plan* which covers the person as a *Dependent* of an *Employee*.

4. *Dependent Child*/Parents Not Separated or Divorced. Except as stated in rule 5, the benefits of the *Plan* of the parent whose birthday falls earlier in the *Calendar Year* are determined before those of the *plan* of the parent whose birthday falls later in that *calendar year*; but, if both parents have the same birthday, then rule 8 applies. However, if the Other *Plan* does not use this "birthday rule", but instead has a rule based upon the gender of the parent, and if, as a result, the *plan*s do not agree on the order of benefits, the rule in the Other *Plan* shall determine the order of benefits.

5. *Dependent Child*/Separated or Divorced Parents. If the parents are separated or divorced, benefits for a *Dependent child* are determined in this order:

    a. first, the *plan* of the parent with primary physical custody of the *child*;

    b. second, the *plan* of the spouse of the parent with the primary physical custody of the *child*; and

c. third, the *plan* of the parent not having primary physical custody of the *child*; and

d. finally, the plan of the spouse of the parent not having primary physical custody of the *child*.

Also, if the specific terms of a court decree state that the parents have joint custody of the *child* and do not specify that one parent has responsibility for the *child*'s health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the *child* but gives physical custody of the *child* to one parent, and the entities obligated to pay or provide the benefits of the respective parents' *plan*s have actual knowledge of those terms, benefits for the *Dependent child* shall be determined according to rule 4.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the *child*, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of those terms, the benefits of that *plan* are determined first. This paragraph does not apply with respect to any *Calendar Year* during which any benefits are actually paid or provided before the entity has that actual knowledge.

The court cannot require the *Plan* to provide coverage to a *child* if the *child* would not otherwise have been eligible under the terms and conditions of this *Plan*.

6. Active/Inactive *Employee*. The benefits of a *plan* which covers a person as an *employee* who is neither laid off nor retired or as that *employee*'s *dependent* are determined before those of a *plan* which covers that person as a laid off or *retired employee* or as that *employee*'s or *retiree*'s *dependent*. If the Other *Plan* does not have this rule and if, as a result, the *plan*s do not agree on the order of benefits, this rule 5 is ignored.

   If a *Dependent* is a *Medicare beneficiary* and if, under the Social Security Act of 1965 as amended, *Medicare* is secondary to the *plan* covering the person as a *dependent* of an active *employee*, the federal *Medicare* regulations shall supersede this rule 4.

7. Continuation coverage. If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

   a. first, the benefits of the plan covering the person as an *Employee* or as a Dependent of an *Employee*; and

   b. second, the benefits under the continuation coverage.

   If the **other plan** contains no provision for coordination of benefits, then the **other plan** pays primary and this *plan* pays secondary.

8. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the *plan* which covered a *Participant* longer are determined before those of the *plan* which covered that person for the shorter period.

9. If the Primary plan is still not established by application of the above rules, then the allowable expenses should be shared equally between the benefit plans meeting the definition of Coordinating plan. In addition, the *City Plan* will not pay more than it would have paid had it been the Primary plan.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with *Medicare* will conform with Federal Statutes and Regulations.

The Plan as Primary / Medicare as Secondary:

This *Plan* is primary when any of the following apply:

1. *You* are a covered *Employee* that is eligible for *Medicare* due to having met the minimum age for *Medicare on* the basis of age, or on the basis or being totally disabled.

2. *You* are a covered spouse of a covered *Employee* and *you* are eligible for *Medicare* due to having met the minimum age for *Medicare* on the basis of age or on the basis of being totally disabled.

3. *You* are a *Dependent* of a covered *Employee* and *you* are eligible for *Medicare* on the basis of being totally disabled.

4. *You* are diagnosed with end-stage renal disease (ESRD) as defined by *Medicare.* The *Plan* is primary for the first 30 months; thereafter, benefits under this *Plan* shall be paid as secondary to the amounts that are payable or could have been payable by *Medicare*.

Medicare as Primary/ Plan as Secondary:

For classifications of eligibility under the *Plan* other than those listed above, benefits under the *Plan* are considered secondary to *Medicare*. When *Medicare* is primary coverage, benefits under the *Plan* are offset for any benefits which are payable under *Medicare* Parts A (*Hospital*), B (Medical) and any other applicable parts.

Effective January 1, 2008 and thereafter, a covered Retired *Employee*, spouse of a covered *Retired Employee* or a Surviving Spouse that meet the eligibility requirements to maintain *Plan* coverage and who are eligible for *Medicare* due to *total disability* are required to apply for *Medicare* Parts A and B at their first enrollment opportunity (following notice from the Plan Administrator). If such covered person fails to apply for *Medicare* Parts A and B at their first enrollment opportunity, the benefits under the *Plan* will be offset for any benefits which would have been payable under *Medicare* Parts A and B had such covered person made a timely enrollment for *Medicare* as described in this paragraph.

Note that this provision does not apply to: a covered spouse (qualifying for *Medicare* based on *total disability*) who is younger than the covered *Retired Employee* and continues *PLAN* coverage following the covered *Retired Employee* aging off the *Plan*), or a covered spouse who is older than the covered *Retired Employee* (including when meeting the minimum age for *Medicare* on the basis of age) until the covered *Retired Employee's* aging off the *Plan*.

If a surviving *Dependent* qualifies for *total disability* under Social Security, coverage under the *Plan* terminates upon eligibility to enroll for *Medicare*.

EFFECT OF COORDINATION OF BENEFITS (COB) ON THE BENEFITS OF THIS PLAN

When, in accordance with the order of benefit determination rules, this *Plan* is a *secondary plan* the benefits of this *Plan* may be reduced. The benefits of this *Plan* will be reduced when the sum of the following exceeds the *allowable expenses* in the *Calendar* Year:

1. the benefits that would be payable for the *allowable expenses* under this *Plan* in the absence of this COB provision; and

2. the benefits that would be payable for the Allowed Expenses under Other *Plan*s, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made. Under this provision, the benefits of this *Plan* will be reduced so that they and the benefits payable under the Other *Plan*s do not total more than those *allowable expenses*.

When the benefits of this *Plan* are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this *Plan*.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION FOR COORDINATION OF BENEFITS

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

The *Plan* has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent.

2. To require that the claimant provide the *Plan* with information on such other plans so that this provision may be implemented.

3. To pay the amount due under this *Plan* to an insurer or other organization if this is necessary, in the *Plan Supervisor's* opinion, to satisfy the terms of this provision.

FACILITY OF PAYMENT

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

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

RIGHT OF RECOVERY

If the amount of the payments made by this *Plan* is more than it should have paid under this COB provision, the *Plan* may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of *services*.

SUBROGATION

A. Payment Condition

1. The *Plan*, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an *injury*, *sickness*, disease or disability is caused in whole or in part by, or results from the acts or omissions of *plan participants* or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "*Plan Participant*") or a third party, where another party may be responsible for expenses arising from an incident and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

2. *Plan participant*, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the ***plan's*** conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the ***plan's*** conditional payment of benefits of the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the *plan* or the ***plan's*** assignee. By accepting benefits the *Plan participant* agrees the *plan* shall have an equitable lien on any funds received by the *Plan participant* and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *Plan participant* agrees to include the ***plan's*** name as a co-payee on any and all settlement drafts.

3. In the event a *Plan participant* settles, recovers, or is reimbursed by any third party or Coverage, the *Plan participant* agrees to reimburse the *plan* for all benefits paid or that will be paid by the *Plan* on behalf of the *Plan participant*. If the *Plan participant* fails to reimburse the *plan* out of any judgment or settlement received, the *Plan participant* will be responsible for any and all expenses (fees and costs) associated with the ***plan's*** attempt to recover such money.

B. Subrogation

To the extent of any payments the *Plan* makes or may be obliged to make for a claim ("Claim"), the *Plan* shall be subrogated to all rights of recovery of a *Participant*, his or her parent(s) and *dependent*(s) or a representative or guardian or trustee of the *Participant*, parent(s) or *dependent*(s) (collectively referred to as "Claimant") relating to the incident. The subrogation right applies to any recovery, whether by suit, settlement or otherwise, whether partial or full recovery and regardless whether Claimant is made whole, from any source liable for making a payment relating to the *injury*, *illness* or condition to which the Claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self funded protection), no fault protection, personal *injury* protection, financial responsibility, uninsured or underinsured insurance coverages, as well as medical reimbursement coverage purchased by the Claimant or any responsible party.

1. The *Plan* has the right to recover amounts representing the *Plan's* subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including but not limited to the initiation of a collection action under any applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

2. As a condition to participating in and receiving benefits under this *plan*, the *Plan participant* agrees to assign to the *plan* the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the *Plan participant* is entitled, regardless of how classified or characterized.

3. If a *Plan participant* receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the *plan* to any claim, which any *Plan participant* may have against any party causing the *sickness* or *injury* to the extent of such conditional payment by the *plan* plus reasonable costs of collection.

4. The *plan* may in its own name or in the name of the *Plan participant* commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the *plan*.

5. If the *Plan participant* fails to file a claim or pursue damages against:

   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal *injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

6. the *Plan participant* authorizes the *plan* to pursue, sue, compromise or settle any such claims in the *Plan participant's* and/or the *plan's* name and agrees to fully cooperate with the *plan* in the prosecution of any such claims. The *Plan participant* assigns all rights to the *plan* or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

1. The *plan* shall be entitled to recover 100% of the benefits paid, without deduction for attorney's fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the *Plan participant* is fully compensated by his/her recovery from all sources. The *plan* shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the *plan's* equitable lien and right to reimbursement. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the *Plan participant* recovery is less than the benefits paid, then the *plan* is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filling fees, or other costs or expenses of litigation may be deducted from the *plan's* recovery without the prior, expressed written consent of the *plan*.

3. The *plan's* right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the *Plan participant*, whether under the doctrines or causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statues, which attempt to apply such laws and reduce a subrogating plan's recovery will not be applicable to the *plan* and will not reduce the *plan's* reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgement of these rights is required by the *plan* and signed by the *Plan participant*.

5. This provision shall not limit any other remedies of the *plan* provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *sickness*, *injury*, disease or disability.

D. Excess Insurance

If at the time of *injury*, *sickness*, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this *plan* shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the *Plan's* Coordination of Benefits Section. The *plan's* benefits shall be excess to:

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

E. Separation of Funds

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

F. Wrongful Death Claims

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

G. Obligations

1. It is the ***Plan participant's*** obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a) to cooperate with the *plan*, or any representatives of the *plan*, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the ***plan's*** rights;
   b) to provide the *plan* with pertinent information regarding the *sickness*, disease, disability, or *injury*, including accident reports, settlement information and any other requested additional information;
   c) to take such action and execute such documents as the *plan* may require to facilitate enforcement of its subrogation and reimbursement rights;
   d) to do nothing to impair or prejudice the ***plan's*** rights of subrogation and reimbursement;
   e) to promptly reimburse the *plan* when a recovery through settlement, judgment, award or other payment is received; and
   f) to not settle or release, without the prior consent of the *plan*, any claim to the extent that the *Plan participant* may have against any responsible party or Coverage.

2. If the *Plan participant* and/or his or her attorney fails to reimburse the *plan* for all benefits paid or to be paid, as a result of said *injury* or condition, out of any proceeds, judgment or settlement received, the *Plan participant* will be responsible for any and all expenses (whether fees or costs) associated with the ***plan's*** attempt to recover such money from the *Plan participant*.

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

H. Offset

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

I. Claims

Any claim relating to the Claim which is first received by the *Plan* after a recovery, regardless of when the claim is incurred, shall be the responsibility of the Claimant to the extent of the Claimant's net recovery and shall be paid by the Claimant and not the *Plan*. In the event the *Plan* inadvertently provides benefits for such a claim, the Claimant shall have an obligation to repay the *Plan* to the extent of the Claimant's net recovery. The *Plan* has the enforcement rights set forth in this section to recover such amounts.

J. Attorney's Fees

The *Plan* specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the *Plan* shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the *Plan* has agreed in writing to pay such fees or costs. The *Plan* specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the *Plan* shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the *Plan* has agreed in writing to pay such fees or costs.

I. Minor Status

1. In the event the *Plan participant* is a minor as the term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the *plan* to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fails to take such action, the *plan* shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

The *plan* administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the *plan's* subrogation and reimbursement rights. The *plan* administrator may amend the *plan* at any time without notice.

K. Severability

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

SECTION VIII - FILING YOUR CLAIMS; APPEALS

HOW TO FILE A MEDICAL CLAIM

You will receive an identification (ID) card which will contain information regarding *your* coverage. Present *your* ID card to the *hospital*, clinic, or *physician*'s office for *services*. The bills can be submitted on the provider's own claim forms and sent directly to the *Plan Supervisor*. No special claim forms are required. *You* can mail the bills to the *Plan Supervisor* if the facility or *physician* providing *services* does not forward them.

If *you* submit *your* claims directly to the *Plan supervisor* for payment or reimbursement *you* must include the following:

1. A copy of the bills for *services* showing: name of patient; name, address, telephone number of the provider of care; diagnosis; type of *services* rendered, with diagnosis and/or procedure codes; date of *services;* and an itemization of the charges;

2. *Your* name, the *Employee*'s Social Security number (or alternative assigned identification number), and the name of the *Plan* (City of La Crosse Medical Benefit *Plan*);

3. For reimbursement to *you*, a copy of the receipt showing that the bill has been paid;

4. If another plan has already made payment as a primary plan, a copy of the explanation of benefits (EOB) statement from the other plan; and

5. If *you have* accumulated bills for medical items *you* purchase or rent *your*self, send them to the *Plan supervisor* at least quarterly during the *calendar year.* The receipts must include the patient name, name of item, date item was purchased or rented and name of the provider of service.

The *Plan supervisor* will make direct payment to the *hospital*, clinic, or *physician*'s office, unless the *Plan supervisor* is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*" and send it directly to the *Plan supervisor*.

When *your* claim is processed by the *Plan supervisor*, *you* will receive a written explanation of the benefits (EOB) statement. This statement will inform *you* of the amount of: total charges, any PPO discount; *co-payment*, *deductible* and *coinsurance;* benefit paid; and any remaining balance for which *you* are responsible. Please retain this statement, as *you* will need it if *you* call with questions or file an appeal on a claim.

If *your dependent child* is subject to a *qualified medical support order*, the *Plan supervisor* will make reimbursement of eligible expenses paid by *you*, the *child*, the *child*'s non-*employee* custodial parent, or legal guardian, to that *child* or that *child*'s custodial parent, or legal guardian, or as provided in the *qualified medical child support order*.

Payment of benefits under this *Plan* will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

The *Plan supervisor* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the *Plan* from further liability.

Any payment made by the *Plan supervisor* in good faith will fully discharge it to the extent of such payment. Payment due under the *Plan* will be paid upon receipt of written proof of loss.

NOTICE OF CLAIM

1. *You* must present *your* identification card to the *hospital, physician* or *other qualified practitioner* or provider, or the fact of participation made known, when *you* obtain *covered services*;

2. If *you* fail to comply with the provisions above, then written notice of the commencement of treatment or *confinement* must be given to the *Plan* within thirty (30) consecutive days after the commencement of such treatment or *confinement*;

3. The *Plan* will not be liable under this *Plan* unless proper notice is furnished to the *Plan* that *covered services* have been rendered to a *participant*. The notice must include the data necessary for the *Plan* to determine benefits. An expense will be considered incurred on the date the service or supply was rendered; and

4. Failure to give notice to the *Plan* within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible.

CLAIM APPEAL PROCEDURE

Notice of Claim

Written notice of claim should be submitted to the *Plan Supervisor* as soon as possible after the date the expense was incurred. In no event will a claim be accepted and paid beyond sixteen (16) months from the date of the expense. Written notice of claim given by or on behalf of the *plan participant* to the *Plan Supervisor*, with information sufficient to identify the *plan participant*, will be considered notice.

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

Claims Procedure

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

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If *you* have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving *Urgent Care* is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

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

In the case of a Claim involving *Urgent Care*, the following timetable applies:

1. Notification to claimant of benefit determination — 72 hours
2. Insufficient information on the Claim, or failure to follow the *Plan's* procedure for filing a Claim:
    - Notification to claimant, orally or in writing — 24 hours
    - Response by claimant, orally or in writing — 48 hours
    - Benefit determination, orally or in writing — 48 hours
3. Ongoing courses of treatment, notification of:
    - Reduction or termination before the end of treatment — 72 hours
    - Determination as to extending course of treatment — 24 hours

If there is an adverse benefit determination on a Claim involving *Urgent Care*, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the *Plan*'*s* benefit determination on review, may be transmitted between the *Plan* and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

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

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

1. Notification to claimant of benefit determination — 15 days
2. Extension due to matters beyond the control of the *Plan* — 15 days
3. Insufficient information on the Claim:
    - Notification of — 15 days
    - Response by claimant — 45 days
4. Notification, orally or in writing, of failure to follow the *Plan's* procedures for filing a Claim — 5 days
5. Ongoing courses of treatment:
    - Reduction or termination before the end of the treatment — 15 days
    - Request to extend course of treatment — 15 days
6. Review of adverse benefit determination — 30 days

- Reduction or termination before the end of the treatment — 15 days
- Request to extend course of treatment — 15 days

Post-Service Claim

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

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

1. Notification to claimant of benefit determination — 30 days
2. Extension due to matters beyond the control of the *Plan* — 15 days
3. Extension due to insufficient information on the Claim — 15 days
4. Response by claimant following notice of insufficient information — 45 days
5. Review of adverse benefit determination — 60 days

Notice to claimant of adverse benefit determinations

Adverse determination means a determination made by the *Plan Supervisor*, to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay or other requested treatment or *services* has been reviewed;

2. Based on the information provided, the requested treatment or service is not *medically necessary* or does not meet the *Plan's* requirements for appropriateness, health care setting, level of care or effectiveness;

3. Based on the information provided, the *Plan Supervisor* reduced, denied, or terminated the treatment or payment, including a denial of your request for a referral to a non-network provider as *you* believe their clinical expertise is *medically necessary* for your care and that expertise is not available from a *network* provider; and

4. The amount of the reduction or cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, the adjusted dollar amount published to the State of Wisconsin Office of the Commissioner of Insurance website. The website will be updated with the Consumer Price Index (CPI) on or before December 1 of each year, effective the following January 1.

Expedited appeal means an appeal to which any of the following apply:

2. The duration of the standard appeal process will result in serious jeopardy to your life or health, or your ability to regain maximum function;

3. Your physician has the opinion that *you* are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal; or

4. Your physician determined that the appeal shall be treated as an expedited appeal.

Appeal means any dissatisfaction, submitted in writing by *you or your* authorized representative, relating to how *we* administered any provision of service or claims practice.

Independent Review Organization (IRO) means an organization of medical professionals with no connection to your health plan, qualified to review your dispute. IRO's must be certified in Wisconsin by the Office of the Commissioner of Insurance. To be certified, the IRO must demonstrate that it is unbiased and has procedures to ensure its clinical peer reviewers are qualified and in*dependent*.

Appeals

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

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

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

1. was relied upon in making the benefit determination;

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

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

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

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

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

EXTERNAL INDEPENDENT REVIEW ORGANIZATION

If *you* disagree with the outcome of your appeal and *we* have rendered an adverse determination which denied, reduced or terminated coverage of a service, *you or your* authorized representative have the right to request a review by an External Independent Review Organization (IRO).

Independent Review Organization (IRO) means an organization of medical professionals with no connection to your health plan, qualified to review your dispute. IRO's must be certified in Wisconsin by the Office of the Commissioner of Insurance. To be certified, the IRO must demonstrate that it is unbiased and has procedures to ensure its clinical peer reviewers are qualified and independent.

External Independent Review Organization Process

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

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is *experimental* or *investigational*), as determined by the external reviewer; and

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

Standard External Review

A standard external review is external review that is not considered expedited.

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

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

1. The claimant is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;

2. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the *Plan* (e.g., worker classification or similar determination);

3. The claimant has exhausted the *Plan's* internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

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

Within one (1) business day after completion of the preliminary review, the *Plan* will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will

include the reasons for its ineligibility and contact information for the *Employee* Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the *Plan* will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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

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

Expedited External Review

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

1. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

2. A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received *emergency services*, but has not been discharged from a facility.

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

Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the *Plan* will assign an IRO pursuant to the requirements set forth above for standard review. The *Plan* will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

SECTION IX - GENERAL PLAN PROVISIONS

IDENTIFICATION CARDS/SUMMARY PLAN DESCRIPTION

1. The *Plan* will provide the *employee* with identification cards for presentation to providers.

2. The *Plan* provides the *employee* with a copy of the *Plan* Document and Summary *Plan* Description.

CONTESTABILITY

The *Plan* has the right to contest the validity of *your* coverage under the *Plan* at any time.

No statement made by an *Employee* with respect to a *participant*'s insurability, except fraudulent misstatements, shall be used to void the *Employee's* contract or to deny a claim for benefits for *services* rendered or a disability commencing after the coverage has been in effect for two (2) years.

Each *Employee* or *Retiree* must make full, accurate and timely reporting in writing to the *Plan Administrato*r of information used in determining eligibility for coverage initially and ongoing while covered under the *Plan*. Such notice must be made within 31 days of the event. This includes any changes in the status of *dependents* as needed for proper administration of the *Plan.* Delayed reporting or misinformation or allowing non qualified persons to use the identification card for benefits may constitute fraud or theft punishable by means determined by the *Plan Administrator* including termination from the *Plan* and as an *Employee.*

RIGHT TO REQUEST OVERPAYMENTS

The *Plan* reserves the right to recover any payment made by the *Plan* that was:

1. Made in error; or

2. Made to *You* or any party on *your* behalf where the *Plan* determines the payment to *you* or any party is greater than the amount payable under this *Plan*.

The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf. At the option of the *Plan*, subsequent payment for benefits or the allowance therefore may be diminished or refused as a set-off toward such reimbursement. As a condition of enrollment, you authorize the deduction of such overpayment from such benefits or other present or future compensation payments.

ASSIGNMENT AND ASSIGNABILITY

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

NATIONAL CORRECT CODING INITIATIVE

Where not otherwise specified, this *Plan* follows National Correct Coding Initiative (NCCI) for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where

NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

PROTECTION AGAINST CREDITORS

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

WORKERS' COMPENSATION

If benefits are paid by the *Plan* and the *Plan* determines *you* received Workers' Compensation for the same incident, the *Plan* has the right to recover as described under the Reimbursement/Subrogation provision. The *Plan* will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course or resulted from *your* employment;

3. The amount of Workers Compensation due to medical or health care is not agreed upon or defined by *You* or the Workers' Compensation carrier; or

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *Plan*, *you* will notify the *Plan supervisor* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the *Plan* as described above.

MEDICAID

This *Plan* will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims. If payment for Medicaid benefits has been made under a state Medicaid Plan for which payment would otherwise be due under this *Plan*, payment of benefits under this *Plan* will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *Employee* to the benefits payment.

CONSTRUCTION OF PLAN TERMS

The *Plan* has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the *Plan*, including, without limitation, the benefits provided thereunder, the obligations of the *Beneficiary* and the recovery rights of the *Plan*; such construction and *prescription* by the *Plan* shall be final and uncontestable unless it can be shown that the interpretation or determination was arbitrary or capricious.

RELEASE OF INFORMATION

A *Participant* shall do all things reasonably necessary to assist the *Plan Supervisor* in determining benefits payable, including but not limited to, the execution of releases authorizing and directing any Provider or other person or corporation by whom or in which dental, medical or surgical treatment or advice is being, shall be or shall have been rendered, to furnish and make available to the *Plan* all such dental, medical or surgical reports, records, radiographs and other information, or copies thereof, as the Plan may request. By accepting coverage under this Plan, you agree that the Plan Supervisor may request, and any third party my give to them, any information (including copies of records) about the medical condition and forms of services prescribed or delivered for which benefits are claimed.

TRANSFER OF BENEFITS

No person, other than the *eligible Plan participant*, as recorded in the office of the *Plan supervisor,* is entitled to benefits under this *Plan*. If the *Employee, Retiree or* any other person aids any person in obtaining benefits under this *Plan* for which not entitled, the *Plan* Holder shall be liable for reimbursement to, of any related monies expended by, the *Plan*.

ENTIRE PLAN; CHANGES

This *Plan*, and any amendments thereto, constitute the entire *Plan* Document. No change in this *Plan* will be effective until approved by the *Plan administrator*. No agent or representative of the *Plan*, other than the *Plan administrator*, may change this *Plan* or waive any of its provisions.

PROOF OF LOSS

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

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained.

PAYMENT OF CLAIMS

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

ASSIGNMENT

Benefits may not be assigned except by consent of the Plan Administrator, other than to providers of medical *services* and according to the provisions set forth in the *Plan* Document. Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no amount payable at anytime hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of

any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The *Plan* shall not be liable for or subject to the debts and/or liabilities of any person entitled to any amount payable under the *Plan* or any part thereof.

RIGHTS OF RECOVERY

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

WORKER'S COMPENSATION NOT AFFECTED

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

LEGAL PROCEEDINGS

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

CONFORMITY WITH GOVERNING LAW

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

TIME LIMITATION

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

STATEMENTS

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

Any Covered Person who knowingly and with intent to defraud the *Plan*, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs, the *Plan* retains a right to the overpayment. The

person, provider, or institution receiving the overpayment will be required to return the overpayment. In the case of a *Plan participant*, if it is requested, the amount of overpayment can be deducted from future benefit payments.

MISCELLANEOUS

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

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

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

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

NOTICE REQUIREMENTS

Any notice required under this *Plan* must be in writing. Notice given to a *Participant* will be sent to the *Participant*'s address as it appears on the records of the *Plan Supervisor*. The *Participant*, may, by written notice, indicate a new address for giving notice.

APPLICABLE LAW

This *Plan* shall be construed under, enforced in accordance with and governed by the provisions of applicable federal, state and local laws. If any provision of this *Plan* is found to be invalid, such provision shall be deemed modified to comply with applicable law and the remaining terms and provisions of this *Plan* shall remain in full force and effect.

HIPAA HEALTH INFORMATION PRIVACY

This *Plan* is subject to the Health insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations (45 C.F.R. Parts 160-164). On the basis of that law, privacy regulations apply to certain protected health information (PHI).

***Plan* Administrator's Certification of Compliance**

Neither the *Plan* nor any health insurance issuer or business associate servicing the *Plan* will disclose *plan participant's* PHI to the *Plan* Administrator unless the *Plan* Administrator certifies that the *Plan* Document has been amended to incorporate this section and agrees to abide by this section.

Purpose of Disclosure to *Plan* Administrator

The *Plan* and any health insurance issuer or business associate servicing the *Plan* will disclose *plan participant's* PHI to the *Plan* Administrator only to permit the *Plan* Administrator to carry out *plan* administrative functions for the *Plan* not inconsistent with the requirements of HIPAA regulations. Information used and disclosed without specific authorization must be for treatment, payment, or healthcare operations. Any disclosure to and use by the *Plan* Administrator of *plan participant's* PHI will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.

Neither the *Plan* nor any health insurance issuer or business associate servicing the *Plan* will disclose *plan participant's* PHI to the *Plan* Administrator unless the disclosures are explained in the Privacy Practices Notice which is distributed to *plan participants*.

Neither the *Plan* nor any health insurance issuer or business associate servicing the *Plan* will disclose *plan participant's* PHI to the *Plan* Administrator for the purpose of employment-related actions or decisions or in connection with any other benefit or *employee* benefit plan of the *Plan* Sponsor.

Restrictions on *Plan* Administrator's Use and Disclosure of PHI

The *Plan* will not disclose protected health information to the *Plan* Administrator unless and until it receives a certification from the *Plan* Administrator that the *Plan* Administrator agrees to:

1. Not use or disclose the information other than as permitted by the *plan* document or required by law.

2. Ensure that any of its agents, including a subcontractor, to whom it provides protected health information, agree to the same restrictions that apply to the *Plan* Administrator with respect to such information.

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the Plan Sponsor.

4. Report to the *Plan* any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware.

5. Provide an individual with access to inspect or to obtain a copy of the protected health information that the *plan* has about the individual upon request.

6. Make available protected health information for amendment and incorporate any required amendments to protected health information.

7. Make available the information required to provide an accounting of disclosures of protected health information about an individual.

8. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the *plan* available to the Secretary of the Department of Health

and Human Services for purposes of determining compliance by the group health plan with this subpart.

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

10. Ensure that the adequate separation between the *Plan* and the *Plan* Administrator is established.

Adequate Separation Between the *Plan* Administrator and the *Plan*

The following *employee*s or classes of *employee*s of the workforce under the control of the *Plan* administrator may be given access to *plan participant's* PHI relating to payment under, health care operations of, or other matters pertaining to the *Plan* in the ordinary course of business:

1. Workforce *member*s with access to PHI related to enrollment, payment of claims, and tracking of disclosures: Human Resources staff who are associated with the processing of this classification of information for the *plan.*

2. *Employee*s with access to PHI related to enrollment status: all staff in the Human Resources Department, Information Systems staff who maintain human resource information systems or print payroll reports, Human Resources Department staff responsible for internal audit functions, and individuals accountable for overseeing budget expenditures for *premium* payments for individuals enrolled under the *plan.*

The *employee*s, classes of *employee*s or other workforce *member*s identified in this section will have access to *plan participant's* PHI only to perform the plan administration functions that the *Plan* administrator provides for the *Plan.*

The *employee*s, classes of *employee*s, or other workforce *member*s identified in this section shall be subject to disciplinary action and sanctions, including termination of employment or affiliation with the *Plan* Administrator, for any use or disclosure of *plan participant's* PHI in breach, violation or noncompliance with the provisions of this section. The *Plan* administrator will promptly report such breach, violation or noncompliance to the *Plan* and will cooperate with the *Plan* to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each *employee* or other workforce *member* causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any *plan participant*, the privacy of whose PHI may have been compromised by the breach, violation, or noncompliance.

HIPAA SECURITY STANDARDS

Definitions used in this section

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

Plan – The term "*Plan*" means the City of La Crosse Medical Benefit Plan.

Plan Documents – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.,* the documents under which the group health plan was established and is maintained), including but not limited to the City of La Crosse Medical Benefit Plan.

Plan sponsor – The term "Plan Sponsor" means the City of La Crosse Medical Benefit Plan.

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

Plan Sponsor Obligations

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

1. *Plan* sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that *Plan* sponsor creates, receives, maintains, or transmits on behalf of the *Plan*;
2. *Plan* sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. *Plan* sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. *Plan* sponsor shall report to the *Plan* any Security Incidents of which it becomes aware as described below:
5. *Plan* sponsor shall report to the *Plan* within a reasonable time after *Plan* sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the *Plan*'*s* Electronic Protected Health Information; and
6. *Plan* sponsor shall report to the *Plan* any other Security Incident on an aggregate basis every quarter, or more frequently upon the *Plan's* request.

DEFINITIONS

Active status means performing on a regular, *full-time* basis (as defined by Common Council resolution) all customary occupational duties at the *employer*'s business locations or when required to travel for the *employer*'s business purposes. An *employee*'s approved paid time off (vacation, sick leave, holidays, compensatory time, bereavement leave, administrative leave), jury duty, required military training for the reserves or national guard up to two weeks per year, FMLA, Worker's Compensation under the *City*'s policy and/or an approved leave of absence without pay for up to 30 days is still considered *active status*.

Ambulatory surgical center is a licensed facility that is used mainly for performing outpatient *surgery*, or renal dialysis procedures on an outpatient basis, has an organized medical staff of *physician*s, has continuous *physician* and nursing care by registered nurses (R.N.s), does not provide for overnight stays is licensed as required by the appropriate governmental agencies and is accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

Approved Clinical Trial: Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition as described by the Patient Protection and Affordable Care Act of 2010 (PPACA). Life-threatening disease is a condition that is likely to result in death unless the course of the condition is interrupted. In addition, the clinical trial must be one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application
3. A drug trial that is exempt from the requirement of an FSA investigational new drug application.

Beneficiary means *you* and *your* covered *dependent*(s), or legal representative of either, and anyone to whom the rights of you or your covered *dependents* may pass.

Birthing center means any freestanding health facility, place, professional office or institution which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to *birthing center*s in the jurisdiction where

the facility is located.

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

Bodily injury means *injury* due directly to an accident and in*dependent* of all other causes. Muscle strain due to athletic or physical activity is considered a *sickness*.

Brand name medication means a medication that has been approved by the FDA for distribution as a brand medication using an NDA (New Drug Application) process by a manufacturer. Can be distributed by one pharmaceutical manufacturer as a single source brand or multiple manufacturers as a multi-source brand as defined by the national pricing standard used by the drug *Plan supervisor*.

Calendar year means January 1st through December 31st each year.

Case management means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

Chiropractic care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *qualified practitioner* to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of or in, the vertebral column.

Child includes the *Employee*'s or Retired *Employee*s:

1. Natural *child*,
2. Legally adopted *child* or *child* placed in the home concurrent with filing for legal adoption.
3. Step *child*
4. Any *child* for whom the *Employee* or *Retired Employee* is named legal guardian.
5. Grandchild:
   a) while both mother and father (who qualify upon birth of such *child* as a covered *family member* under an *Employee* or Retired *Employee*) and such *child* are under age 18 and,
   b) while mother or father of such *child* remain covered as a *Child*.
   c) who is not eligible for other group coverage.
6. Any other *child* for whom a *Qualified Medical Child Support Order* (QMCSO) or a Qualified Domestic Relations Order (QDRO).
7. A *child* born outside of marriage to a male covered *Employee* or *Retired Employee* shall not become an eligible *dependent* until the date:
   a) The court order declaring paternity, or
   b) The acknowledgement of paternity is filed with the Wisconsin Department of Health and Family Services or equivalent if the birth occurred out of Wisconsin,
   c) Providing such father is covered under the plan as a covered *Employee* or covered Retired *employee*, or covered *family member* on such day (or the day of death of the covered *employee* or Retired *Employee*).

City means the City of La Crosse, in the State of Wisconsin and each governmental subsection.

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

Coinsurance means a shared liability between the *Plan* and *participant* for a covered service.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy* but adversely affected by *pregnancy* or caused by *pregnancy*. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A nonelective cesarean section surgical procedure;

3. Terminated ectopic *pregnancy*; or

4. Spontaneous termination of *pregnancy* which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of *pregnancy;*

4. Conditions associated with the management of a difficult *pregnancy* but which do not constitute distinct *complications of pregnancy;* or

5. An elective cesarean section.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, *outpatient care*, and other health care *services*.

Confinement means being a resident patient in a *hospital* or *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinement*s are considered one *confinement* if:

1. Due to the same *bodily injury* or *sickness*; and

2. Separated by fewer than 30 consecutive days when *you* are not confined.

Co-payment (medical) means the amount to be paid by *you* for each applicable medical service.

Co-payment (*prescription* drug) means the amount to be paid by *you* toward the cost of each separate *prescription* order or refill of a covered drug when dispensed by a *participating pharmacy*.

Cosmetic means *services* performed, and supplies and drugs provided for the purpose of cleansing, beautifying, promoting attractiveness, or altering the appearance, as determined by the *Plan Supervisor* in accord with industry standards, rather than for:

1. restoring critical bodily function, or

2. correcting deformity resulting from:

   a) disease,
   b) trauma,
   c) congenital or developmental anomalies, or
   d) previous therapeutic processes.

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Covered services means a service or supply specified in the *Plan* for which benefits will be provided when rendered by a provider and documented in the provider's records. A charge for a *covered service* is considered to have been incurred on the date the service or supply was provided to a *participant.*

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, preparing special diets, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended

or performed the *services*. *Services* may still be custodial even though such *services* involve the use of technical medical skills if such skills can be easily taught to a lay person. Custodial also means the following types including but not limited to:

1. Rest cures

2. Respite care

3. Personal or home *services* provided by *family members*

4. *Services* for coma stimulation or arousal related to disorders of consciousness, and when a *plan participant* is diagnosed as being comatose for more than 30 days without marked improvement, and

5. *Services* for a *participant* in a persistent vegetative state (commonly meaning a brain damaged vegetative state of more than 30 days without any sign of improvement).

Deductible is a specified amount of covered charges that must be incurred by a *participant* before the *Plan* will assume any liability for the remaining charges.

Dental injury is an *injury* caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Dependent means:

1. The covered *Employee*'s or covered Retired *Employee*'s spouse based on a legal union as recognized by the State of Wisconsin..

a) The covered *Employee*'s or covered Retired *Employee*'s *Child (*a natural *child*, step *child*, legally adopted *child*, or a *legal ward* of the *Employee* or *Retired Employee)* meeting one of the following criteria pursuant to the terms and conditions of the Patient Protection and Affordable Care Act (PPACA):

i) The *child* can be married or unmarried; and

ii) The *child* must not yet have attained age 26.

2. An unmarried *child* over age 26 when determined by the *Plan Supervisor* to be incapable of self-sustaining employment by reason of total and permanent disability and *dependent* for at least 50% support (as specified by the Internal Revenue Service) from the *Employee* or Retired *Employee*.

Proof of total and permanent disability must be submitted to the *Plan Supervisor* within 31 calendar days of the date coverage would have ended due to the age limit of the *child*. Disabled *child* must have been covered under the plan on the day prior to the day coverage would have ended due to the age limit of the *child*.

3. A *child* for whom a *Qualified Medical Child Support Order* (QMCSO) has been issued in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA-93) or a Qualified Domestic Relations Order (QDRO).

4. The *child* of a covered *Dependent child* (grandchild of covered *Employee* or Retired *Employee*) only if *Dependent child* is covered under the *Plan* and only until the *Dependent child* is 18 years of age.

Diagnostic service means a test or procedure used to determine a definite condition or disease. A *diagnostic service* must be ordered by a *physician* or *qualified practitioner*.

Drug list means a list of drug products, approved by the drug *Plan supervisor*, that are available under the *Plan* for use by *you*.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*. *Durable medical equipmen*t does not include: items and self-help devices not chiefly medical in nature; items for comfort and convenience; physician's equipment; disposable supplies unless provided in connection with direct physician care or covered *home care*; or, exercise and hygienic equipment.

Effective date means the date on which a *participant*'s coverage under the *Plan* becomes effective.

Eligibility date means the first day the *employee* or *dependent* was eligible to enroll in the *Plan.*

Emergency means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment. This includes, but is not limited to:

A. an initial accidental *bodily injury*, or

B. other sudden onset of acute symptoms, or sufficient severity, including severe pain, to lead a prudent layperson to reasonable conclude that a lack of immediate professional medical attention would likely result in any of the following:

   i. Serious jeopardy to the *plan participant's* health. With respect to a pregnant woman, it includes serious jeopardy to the unborn *child*.
   ii. Serious impairment to the *plan participant's* bodily functions.
   iii. Serious dysfunction of one or more of the *plan participant's* body organs or parts.

C. Examples include:

   i. Acute allergic reactions,
   ii. Acute asthmatic attacks,
   iii. Convulsions,
   iv. Epileptic seizures,
   v. Acute hemorrhage,
   vi. Acute appendicitis,
   vii. Coma,
   viii. Heart attack
   ix. Stroke,
   x. Drug overdoses,
   xi. Loss of consciousness,
   xii. Any condition for which *you* are admitted to the *Hospital* as an inpatient from an *emergency* room.

Employee means a person:
Who is employed for regular wage or salary, is classified as regular *full-time* (as defined per Common Council legislation) applicable to his/her employment classification, and performing the customary occupational duties:

Who meets the minimum hour requirement (as specified):

a. Initially upon hire, and
b. Thereafter when a formal reclassification of employment status is made by the *City* and;
c. Who is not classified by the *City* as temporary, substitute, occasional, seasonal, a co-op student, or independent contractor.

Employer means the *City* of La Crosse*.*

Expense incurred means the fee charged for *services* provided to *you*. The date a service is provided is the *expense incurred* date.

Experimental, investigational or for research purposes means treatment or procedures not generally proven to be effective as determined by the *Plan Supervisor* following review of research protocol and individual treatment plans. *Experimental* or *Investigational* is defined as treatments, procedures, drugs or medicines which the *Plan Supervisor* determines are *experimental* or *investigational*, and that includes at least one of the following:

- The device, drug or medicine cannot lawfully be marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedures, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or *Investigational* arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Note that non-duplicated normal standard of care *services* that would standardly be covered under the *Plan* will continue to be covered.

Family member means *you or your* spouse, or *you* or *your* spouse's *child*, brother, sister, parent, grandchild, or grandparent.

Formulary means a list of preferred *prescription* medications established to be chemically sound and cost effective by a committee of prescribers and *pharmacists* and selected for coverage under the *Plan*.

Free-standing surgical facility means a public or private establishment licensed to perform *surgery* and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Full-time means a person who is employed for regular wage or salary, who is regularly scheduled to work the amount of hours as defined by Common Council resolution and who performs the customary occupational duties.

Functionally Necessary means

1. the *services* or supplies that are required to diagnose or treat a *plan participant's* dental disease or *injury*, as determined by the *Plan Supervisor* to be in accord with broadly accepted, high, professional standards of dentistry:

    a. consistent with the symptoms of such dental disease or *injury*; and

    b. of proven value or usefulness, that is, likely to yield further information and not redundant with other procedures; and

    c. appropriate treatment for such dental disease or *injury* and there is a reasonable expectation that such *services* would cause such dental disease or *injury* to improve to a level of common functionality for chewing and speech; and

    d. the least restrictive, least intrusive, and most appropriate means to safely treat such dental disease or *injury* and in the most economical manner (which means alternative procedures, courses of treatment, or filling materials that can reasonably produce a functional result and be rendered safely); and

e. essential, that is, if the *services* were omitted, such dental disease or *injury* and related functionality for chewing and speech would be adversely impacted; and

f. not primarily *cosmetic* or for the personal comfort or convenience of the *plan participant*, the family, or *qualified practitioner*; and

g. neither *Experimental* nor Investigative.

2. In addition to the above, the following item shall be considered to be *FUNCTIONALLY NECESSARY* for purposes of determining benefit payments when determined to be consistent with the standards of good clinical practice:

a. a crown installed within six months of an allowable root canal therapy performed on such tooth regardless of whether such additional crown was necessary due to such tooth being defective at such time.

Generic medication means a drug identified by the *Pharmacy* & Therapeutics Subcommittee of the *Prescription* Drug *Plan Supervisor* (*Pharmacy* Benefits Manager) to contain identical amounts of the same active drug ingredient in the same dosage form and route of administration that is expected to have the same clinical effects and safety profile as another product as designated by the U.S. Food and Drug Administration.

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

Home health care agency means an organization whose main function is to provide *home health care services and supplies*, is federally certified as a *Home health care agency, and* is licensed by the state in which it is located, if licensing is required.

Home health care services and supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide *services* provided through a *Home health care agency* (this does not include general housekeeping *services*): physical, occupational and speech therapy; medical supplies; and laboratory *services* by or on behalf of the *Hospital*.

Hospice care agency means an organization which has the primary purpose of providing hospice *services* to terminally ill patients. It must be licensed by the state in which it is located, if licensing is required, and meet all of these requirements:

1. has obtained any required certificate of need;

2. provides 24-hours a day, 7 days-a-week service supervised by a *qualified practitioner*;

3. has a *full-time* coordinator;

4. keeps written records of *services* provided to each patient;

5. has a nurse coordinator who is an R.N., who has four years of *full-time* clinical experience, of which at least two involved caring for terminally ill patients; and

6. has a licensed social service coordinator.

Hospice care plan means a plan of terminal-patient care that is established and conducted by a *hospice agency* and supervised by a *physician*.

Hospice care services and supplies means those provided through a *hospice agency* and under a *hospice care plan* and include inpatient care in a *hospice unit* or other licensed facility, home care, and family counseling during the bereavement period.

Hospice unit means a facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two unrelated persons who are expected to die within six months.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a *physician* and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing *services*;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with

7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution which is principally a rest home, *skilled nursing facility*, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence or *mental disorder*s.

Illness means a bodily disorder, disease, physical *sickness* or *mental disorder*. *Illness* includes *pregnancy*, childbirth, miscarriage or *complications of pregnancy*.

Injury means an accidental *bodily injury* caused by an external force, occurring while this *Plan* is in effect. All injuries to one person from one accident shall be considered an "*injury*".

Intensive care unit means a separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the *hospital and* special life saving equipment for immediate use.

Late applicant means an *employee* and/or an *employee*'s eligible *dependent* who applies for *Plan* coverage more than 31 days after the *eligibility date* unless enrolling due to *Special Enrollment*.

Legal ward is a *child* who is less than 18 years of age for whom the *Employee* has been appointed legal guardian by a court. *Legal ward* does not include foster children.

Legend drug means any medicinal substance the label of which, under the Federal Food, Drug and *Cosmetic* Act, is required to bear the legend: "Caution: Federal law prohibits dispensing without *prescription*."

Maintenance care means various types of healthcare services delivered after the acute phase of a disability, mental *illness* or chemical dependency has passed. A progression from therapeutic to maintenance types of *services* begins when a patient's recovery has reached a plateau on the basis of therapeutic *services* or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated or expected. The determination of what constitutes maintenance *services* is made by the *Plan Supervisor* after reviewing such covered person's case history or treatment plan submitted by the Physician or *Qualified Practitioner*.

Maximum allowable fee for a service means the lesser of:

1. The fee most often charged in the geographical area where the service was performed;

2. The fee most often charged by the provider;

3. The fee which is recognized as reasonable by a prudent person;

4. The fee determined by comparing charges for similar services to a national data base adjusted to the geographical area where the *services* or procedures were performed; or

5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *participant*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the maximum is reached.

Medical care facility means a *hospital*, a facility that treats one or more specific ailments, or any type of *skilled nursing facility*.

Medically necessary* or *medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioner*s who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. Of proven value or usefulness, that is, likely to yield further information and not redundant with other procedures, and there is a reasonable expectation that the *participant's* condition will improve due to the treatment;

2. the least restrictive, least intrusive, and most appropriate means to safely treat the disability, mental *illness* or chemical dependency in accord with the standards of good medical practice and in the most economical manner (which in the case of inpatient care, means only those *services* that cannot be rendered safely on an outpatient basis);

3. Not provided primarily for the convenience or personal comfort of the patient or the *qualified practitioner*;

4. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

5. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

6. Essential, that is, if the *services* were omitted, the *sickness* or *bodily injury* would be adversely impacted;

7. Substantiated by the records and documentation maintained by the provider of service;

8. is neither *experimental* or investigative.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder means a mental, nervous or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of *Mental Disorder*s, regardless of the cause or causes of the disease or disorder.

Monthly Plan Contribution* or *Contribution means the portion of the *monthly plan cost* determined by the *City* in accordance with any applicable collective bargaining agreements and/or *City* resolutions covering the terms and conditions of employment for non-represented *employee*s, to be paid on a regular basis each month by the covered *employee*, covered retired *employee*, *COBRA Participant* (plus surcharge permitted by law) or covered surviving spouse and/or *dependent* as specified in the *plan* or

other binding written directive by the *City*. When an event occurs that would result in a change in the amount of a monthly plan contribution, the following shall apply:

a. If the event occurs between the 1st and 15th day of the month, the change in the monthly plan contribution shall be effective that month.
b. If the event occurs between the 16th through the end of the month, the change in the monthly plan contribution shall be effective the next month.

Monthly Plan Cost means the estimated costs to operate the *Plan* for a prospective period of time averaged to a monthly amount. This will be determined by the *City* taking into account previous years' claims experience and changes in *plan* design, medical cost inflation, administrative service fees, stop-loss or reinsurance premium rates, reserve requirements for the *Plan*, demographic and enrollment patterns, etc. Such *monthly plan cost* shall be calculated in terms of cost per tier of coverage available for *plan participants*:

1. *Employee*, *Retired Employee* or Surviving *Family Member* only;

2. two married adults, or a single parent with *child*; and

3. full family

Morbid obesity means a diagnosed condition in which all of the corresponding criteria apply:

a. Non-surgical methods of weight loss have been supervised by a Physician within two years prior to the proposed *surgery* without success, as documented by a Physician who does not perform bariatric *surgery*; History of failed non-surgical attempts at weight loss must include active participation in a structured and supervised weight loss program for a minimum of six months within the last two years. At least three of those months must be consecutive without gaps. There must be documentation in the medical records verifying this or verification by the provider of the weight loss program. This documentation must include weight data as well as documentation that diet, exercise and behavior modification information was addressed;

b. There is evidence of medical complications due to obesity;

c. There are no serious contraindications for *surgery* (*participant* is determined to be a good surgical candidate);

d. Body Mass Index (BMI) as defined as weight in kilograms, divided by height in meters squared of greater than 40 (>40).BMI >40 must have documentation of being present over at least a 2 year time frame (does not mean the BMI has to have been >40 for this whole time frame). BMI greater than 35 for a minimum of two years if one of more significant co-morbid conditions exist requiring ongoing medical management and which are likely to be improved or eliminated by obesity surgical treatment:

e. Age greater than 18

f. No evidence for untreated/uncontrolled mental health/AODA disease.

g. If approved, coverage is limited to one surgery per member's lifetime, regardless of payer. However, surgical revisions will be covered on a case by case basis as determined by the Plan Supervisor's Medical Management. Examples of revisonal procedures for complications include but are not limited to: gastrogastric fistulas (may manifest as weight regain); refractory or recurrent marginal ulcers; J-J intussusception; Roux-limb stasis and SMA syndrome. Revisions will not be covered for weigh regain or failed weight loss.

h. Documentation of willingness to comply with the preoperative and postoperative treatment plans.

Network means the Healthcare providers and pharmacies under contract with the Preferred Provider *Networks* selected by the *City* or by a direct agreement with the *City* to provide specified *services* to covered *participants* for pre-established fees incorporating a discount. The term *Network* may include a supplemental Center of Excellence arrangement with specialty *hospitals* limited to organ transplants and types of *services* not performed in the local service area of the *Network*.

A referral by a *Network* physician to any out-of-network provider does not change the level of coverage as if such out-of-network provider was in the *network* except when such specialty type of service is not available in the *network* as determined by the medical director of the *network* and the *utilization review* organization.

No-fault auto insurance is the basic reparations provision of a law providing for payment without determining fault in connection with automobile accidents.

Non-participating pharmacy or out-of-network means a *pharmacy* which has not entered into an agreement with the drug *Plan supervisor* to participate as part of the *pharmacy network*.

Outpatient care means a treatment including services, supplies and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or *services* rendered in a *physician*'s office, clinic, sub-acute care center, *urgent care center*, laboratory or X-ray facility, *ambulatory surgical center*, or the patient's home.

Participant or ***Plan Participant*** is any Covered *Employee, Dependent, Retired Employee, Dependent* of a *Retired Employee, COBRA participant*, *Surviving S*pouse or Surviving *Dependent* who is covered under this *Plan*.

Participating pharmacy means a *pharmacy* which has entered into an agreement to participate as part of the *pharmacy network* to dispense covered drugs to *you* and *your* covered *dependents* and to accept as payment the *your* drug *co-payment* amount and the amount of the benefit payment provided by the *Plan*.

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Plan means the City of La Crosse Medical Benefit *Plan*.

Plan Supervisor the Claims Administrator, Third Party Administrator or Pharmacy Benefit Manager that provides *services* to the *Plan* Administrator, as defined under the *Plan supervisor* agreement. The *Plan supervisor* is not the *Plan* Administrator or *Plan* Sponsor.

Plan year means a period of time beginning on the *Plan* anniversary date of any year and ending on the day before the same date of the succeeding year. The *Plan* year is January 1 through December 31 of each year.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-*emergency hospital* admissions, surgical procedures, *outpatient care*, and other health care *services*.

Predetermination of benefits means a review by the *Plan supervisor* of a *qualified practitioner*'s treatment *Plan*, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

Pregnancy means childbirth and conditions associated with *pregnancy*, including complications.

Prescription means a direct order for the preparation and use of drug, medicine or medication. The

drug, medicine or medication must be obtainable only by *prescription*. The order must be given verbally or in writing by a *qualified practitioner* (prescriber) to a *pharmacist* for the benefit of and use by a *participant*. The *prescription* must include:

1. The name and address of the *participant* for whom the *prescription* is intended;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the *prescription* was prescribed; and

4. The name, address and DEA number of the prescribing *qualified practitioner*.

Preventive Care means a pattern of medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Screening tests, and immunization programs are common examples of preventive or *Routine Care*.

Primary care physician means a *physician* who practices in family practice, general practice, internal medicine, obstetrics-gynecology, pediatrics, or *urgent care*.

Qualified medical child support order means a state court order or judgment, including approval of a settlement agreement which:

1. Provides for support of a covered *employee*'s *child*;

2. Provides for health benefit coverage to the *child*;

3. Is made under state domestic relations law;

4. Relates to benefits under this *Plan*; and

5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

It also means a state court order or judgment that enforces a state Medicaid law regarding medical *child* support required by the Omnibus Budget Reconciliation Act of 1993.

Qualified practitioner means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Physician's Assistant, Certified Nurse Practitioner, Certified Surgeon's Assistant, Dietician, *Pharmacist*, Licensed Professional Counselor, Licensed Professional Physical Therapist, Respiratory Therapist, Speech Therapist, Certified Nurse, Midwife, Occupational Therapist, Optometrist (O.D.) Physiotherapist, Psychotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license. *Services* provided by these practitioners must be ordered by a physician.

Retired Employee or Retiree means *a former employee provided they:*

1. Meet the minimum attained age and years of *CITY* service eligibility criteria as specified in the applicable collective bargaining agreement or Employee Handbook or defined within this Plan Document applicable to the *Employee* at the time of termination , and

2. Were hired full time prior to 7/1/13 or 1/1/14 as specified in the respective collective bargaining agreement or Employee Handbook or defined within this Plan Document, and

3. Is receiving the monthly retirement annuity under the Wisconsin Retirement System on the basis of:
    a. age,

b. duty or non disability, or
c. Long Term Disability Insurance (LTDI)

4. And is not otherwise eligible to enroll in *Medicare* on the basis of age.

Routine care or ***Preventive Care*** means *services* provided on a periodic basis to medically evaluate the *participant,* but may not be *medically necessary.* These *routine care* benefits are provided when the *participant* is not confined in a *hospital* or *qualified treatment facility* and such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

Self-administered injectable drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and intended for use by *you*.

Services means procedures, surgeries, *exams*, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

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

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

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

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

4. It maintains a complete medical record on each patient;

5. It has an effective *utilization review plan*;

6. It is not, other than incidentally, a place for rest, the aged, the chemically *dependent*, the mentally ill, the mentally retarded, a place for *custodial care* or educational care or care of *mental disorder*s; and

7. It is approved and licensed by *Medicare*.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation, *hospital* or any other similar nomenclature.
Specialist includes *qualified practitioner* as defined, and other than those specified as *primary care physician*s under the *Plan*.

Substance abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Surviving Spouse or Dependent means the lawful Spouse or eligible *Dependent*s of a Covered *Employee* or Covered *Retired Employee* that dies before the *Employee* or *Retired Employee* becomes eligible for *Medicare* due to age.

Timely applicant means an *employee* and/or an *employee*'s eligible *dependent* who applies for medical coverage within 31 days of the *eligibility date*.

Total disability* or *totally disabled means when a disability, mental illness or chemical dependency prevents the covered *participant* from performing:

1. the substantial and material duties of his or her regular job as determined by the *Plan* Supervisor based on the definition of the Social Security Administration (if the covered *participant* is an *Employee* or an employed *Dependent*).

2. the essential activities of daily living that a healthy person of similar age would perform, as determined by the *Plan* Supervisor (if *participant* is a *dependent* who is not in employment status).

Urgent care means events determined to require prompt professional *services* but not be an *Emergency – services* that can be safely postponed until travel to a Physician or *Urgent Care Center* Examples of such qualifying events include but are not limited to: minor cuts, sprains, most drug reactions, non-severe bleeding, and minor burns.

Urgent Care Center means a facility licensed by federal or state law to provide healthcare *services* under the direct supervision of a Physician for non-*emergency* but *Urgent Care*.

Usual and Customary (U&C) charge refers to the designation of a charge as being the usual charge made by a Physician or other provider of *services*, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a *City* or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise. The *Plan* Administrator has the final and discretionary authority to determine the Usual & Customary Fee. Claim data available to the *Plan* Supervisor is used as a basis for setting such maximums from time to time.

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, *outpatient care*, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Visit or *exam* means a visit, call, encounter, *exam*, or consultation by a Physician or *Qualified Practitioner* for preventive *services* or for *sickness* or *bodily injury* in any type of setting (in patient or out patient) for which a separate charge is made for such encounter.

We means the City of La Crosse, or their duly authorized agents.

You* or *your means any *plan participant*, unless the *Plan* document language refers specifically to the *employee, Retired Employee, Younger Spouse, COBRA Participant, Surviving Spouse, Surviving Dependent,* or *dependent*.

Younger Spouse means a younger spouse of a covered *Retired Employee* whose coverage terminates due to the covered Retired *Employee*'s eligibility for *Medicare* on the basis of age shall be eligible for continued coverage under the *Plan*. Such younger spouse and *dependent*s must be covered under the *Plan* on the on the day preceding the Covered *Retired Employee* becoming eligible for *Medicare* on the basis of Age.

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ADDENDUM A

Retiree Medical Benefit Plan Coverage - Normal Service

Group	Hire date	Years of Service Required	Minimum Age
Police Non-Sups (LPPNSA Local #26)	Hired as of 6/30/2004	15 years of full time continuous service	53 or take an early retirement in conjunction with a special early retirement program.
	7/1/2004 - 12/31/2006	18 years of full time continuous service	
	1/1/2007 - 6/30/2013	20 years of full time continuous service	
	Hired on or after 7/1/2013	Not eligible	Not eligible
Police Supervisory (LPPNSA Local #91)	Hired as of 6/30/2004	15 years of full time continuous service	53 or take an early retirement in conjunction with a special early retirement program.
	7/1/2004 - 12/31/2006	18 years of full time continuous service	
	1/1/2007 - 6/30/2013	20 years of full time continuous service	
	Hired on or after 7/1/2013	Not eligible	Not eligible
Fire (IAFF Local #127)	Hired as of 6/30/2004	15 years of full time continuous service	53 or take an early retirement in conjunction with a special early retirement program.
	7/1/2004 - 12/31/2006	18 years of full time continuous service	
	1/1/2007 - 6/30/2013	20 years of full time continuous service	
	Hired on or after 7/1/2013	Not eligible	Not eligible
Transit (ATU Local #519) (Full time employees)	Hired as of 6/30/2004	10 years of continuous employment with City	55 or take an early retirement in conjunction with a special early retirement program.
	7/1/2004 - 12/31/2006	15 years of full time continuous service	
	1/1/2007 - 12/31/2013	20 years of full time continuous service	
	Hired on or after 1/1/2014	Not eligible	Not eligible
Non-Represented (EE Handbook)*; and Library			
City Executives	Hired prior to 1/1/2014	10 years of continuous employment	55 or take an early retirement in conjunction with a special early retirement program.
	Hired on or after 1/1/2014	Not eligible	Not eligible
Non-City Executives			
A. General	Hired prior to 1/1/2002	10 years of continuous employment	55 or take an early retirement in conjunction with a special early retirement program.
	1/1/2002 - 12/31/2006	15 years of regular full time continuous service	
	1/1/2007 - 12/31/2013	20 years of regular full time continuous service	
	Hired on or after 1/1/2014	Not eligible	Not eligible
B. Protective	Hired prior to 1/1/2002	15 years of continuous employment	53 or take an early retirement in conjunction with a special early retirement program.
	1/1/2002 - 12/31/2006	18 years of continuous service	
	1/1/2007 - 12/31/2013	20 years of continuous service	
	Hired on or after 1/1/2014	Not eligible	Not eligible

* "Hire date" for part-time employees who became full time after January 1, 2014, is the date in which they were transferred or promoted to the regular full time position. "Hire date" for part-time employees who became full time on or before December 31, 2013 is based on their adjusted hire date.

Applicable to all: 1. Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM B

Medical Benefit Plan Coverage - Non-Duty Disability Pension; and LTDI

Group		Years of Service Required
Police Non-Sups (LPPNSA Local #26)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LDTI the benefit ends when WRS terminates the employees LDTI benefit.
Police Supervisory (LPPNSA Local #91)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LDTI the benefit ends when WRS terminates the employees LDTI benefit.
Fire (IAFF Local #127)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LDTI the benefit ends when WRS terminates the employees LDTI benefit.
Transit (ATU Local #519) (Full time employees)	Hired prior to 1/1/2014	10 years of continuous employment with City Ends when retiree becomes eligible for Medicare Under LDTI the benefit ends when WRS terminates the employees LDTI benefit.
Non-Represented (EE Handbook)*; and Library	Hired as regular full time prior to 1/1/2014	10 years of service as regular full time employee Ends when retiree becomes eligible for Medicare Under LDTI the benefit ends when WRS terminates the employees LDTI benefit.

* "Hire date" for part-time employees who became full time after January 1, 2014, is the date in which they were transferred or promoted to the regular full time position. "Hire date" for part-time employees who became full time on or before December 31, 2013 is based on their adjusted hire date.

Applicable to all: 1. Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM C

MEDICAL BENEFIT PLAN COVERAGE WHILE ON INCOME CONTINUATION INSURANCE

Full time employees who are participants in the City's medical benefit plan and are receiving the Income Continuation Insurance (ICI) benefit shall receive the same medical benefit plan benefits including contribution rates on the same basis as in effect for active employees, provided that they have a minimum of ten (10) years of continuous service as a full time employee for the City of La Crosse. This benefit ends when the employee becomes eligible for a Wisconsin Retirement System benefit of any kind (i.e. Normal Retirement pension, Duty Disability Retirement, Disability Retirement, or long Term Disability Insurance) or Medicare or Medicaid or for a period of one (1) year while on ICI, whichever occurs first.

Covered employees shall pay the same monthly contribution rates as are in effect for active employees as modified form time to time.

Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM D

RETIREE MEDICAL BENEFIT PLAN – DUTY DISABILITY

Full time employees who receive a duty disability pension shall receive the same benefits, including contributions, on the same basis as is in effect for active employees. This benefit ends when the retiree becomes eligible for Medicare. (For employees covered under the Employee Handbook, Library manual or ATU Local #519 collective bargaining agreement, this provision is only applicable to full time employee hired prior to January 1, 2014.)

Covered retirees shall receive the same plan design as active employees, as modified from time to time. Additionally they shall pay the same monthly rate contributions as in effect for active employees as modified from time to time.

Retirees, surviving spouse and dependents of retirees whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants.

ADDENDUM E

RETIREE MEDICAL BENEFIT PLAN – YOUNGER SPOUSE

When an eligible retiree (see addendum A) reaches Medicare age and his/her spouse is younger, the spouse may elect to continue his/her coverage in the City's medical benefit plan until the spouse reaches Medicare age provided that the spouse pays the total monthly pseudo premium rate. The eligible younger spouse of the retiree shall receive the same plan design as active employees.

Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

Retirees, surviving spouse and dependents of retirees whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants.

ADDENDUM F

ONE PLAN FOR MARRIED EMPLOYEES

Married employees that both work for the City shall be limited to one medical benefit plan. Married employees that both work for the City would be allowed to switch "subscribers" during open enrollment if allowed to do so by state and federal law. In the event that the subscriber's medical benefit plan is terminated, the remaining employee shall become the subscriber and the former subscriber shall become the dependent without any waiting periods.

ADDENDUM G

RETIREE MEDICAL BENEFIT PLAN – MEDICARE CARVE-OUT FOR DISABILITY

Make Whole:
Employees who retired on or before 12/31/2014, and who were participating in Medicare Part B as of 12/31/2014: The City shall make whole any retiree, spouse of current retiree, or surviving spouse for his/her Medicare Part B premium payments and waive the monthly retiree or surviving spouse benefit plan contribution. If a spouse of a current retiree meets this provision, the retiree's monthly benefit plan contribution shall be waived.
Employees who retire after 12/31/2014: The retiree's monthly out of pocket premium costs for the combined costs of Medicare Part B and City's retiree medical benefit plan shall not exceed the cost of the City's monthly retiree or surviving spouse monthly benefit plan contribution. If the cost of Medicare Part B is less than the cost of the City's monthly retiree or surviving spouse benefit plan contribution, the retiree or surviving spouse shall only pay to the City the difference. If the cost of Medicare Part B is more than the cost of the City's monthly retiree or surviving spouse benefit plan contribution, the City would provide the retiree/surviving spouse with an offset equal to the difference.
Eligible retiree, spouse of current retiree, or surviving spouse shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM H

COVERAGE FOR SPOUSE & DEPENDENTS OF ELIGIBLE EMPLOYEES / RETIREES THAT DIE

Spouse and/or eligible dependents of an insured employee/retiree who dies before the employee/retiree becomes eligible for Medicare, shall be eligible to continue to participate in the City's medical benefit plan if they have met the years of service requirement and date of hire provisions as defined in Addendum I.

Covered spouse and dependents of employees/retirees that die shall receive the same plan design as active employees, as modified from time to time. Additionally they shall pay the same monthly rate contributions as in effect for active employees as modified from time to time.
Surviving spouse and/or dependents of deceased employee/retiree whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants

ADDENDUM I

COVERAGE FOR SPOUSE AND DEPENDENTS OF ELIGIBLE EMPLOYEES/RETIREES THAT DIE
(Refer to Addendum H for specific coverage details)

Group	Hire date	Years of Service Required
Police Non-Sups (LPPNSA Local #26)	NA	NA
Police Supervisory (LPPNSA Local #91)	NA	NA
Fire (IAFF Local #127)	NA	NA
Transit (ATU Local #519) (Full time employees)	Hired prior to 1/1/2014	8 years of full time consecutive service
Non-Represented (EE Handbook)*; and Library	Hired prior to 1/1/2012	Must have met eligibility requirements for retiree medical insurance as defined in Addendum A
	Hired on or after 1/1/2012	NA

ADDENDUM J

Health Care Cost Containment

The City will provide money for health care cost containment initiatives for bargaining unit members, and for employees covered under the Employee Handbook. The sum of money provided for these initiatives shall be based upon the number of regular full time members employed (within the applicable bargaining unit or Employee Handbook) as of January 1st of each respective year at a rate of $50 per bargaining unit member/employee. Such funds are to be allocated as determined by the Health Care Cost Containment Committee. Committee expenses up to $1,000 per year may be authorized by the Director of Human Resources. The funds for the health care cost containment shall be established for each individual unit, specifically LPPNSA, LPPSA, IAFF, ATU, and Employee Handbook.

ADDENDUM K

Surgery For Morbid Obesity – Limited Exception/Coverage

Surgery for Morbid Obesity is not a covered benefit effective January 1, 2016 for non-ATU Local #519 covered members. The exception to this is for non-ATU Local #519 members covered as of December 31, 2015 who have completed the required treatment plan (as defined in this Master Plan Document) as of December 31, 2015. If this requirement has been met, coverage for the covered member's morbid obesity surgery, as well as any follow-up care or care for surgical complications due to the morbid obesity surgery will be covered during the initial two months of 2016 only.

Covered non-ATU Local #519 members who had the surgery for morbid obesity prior to December 31, 2015, as a covered member, would be eligible for follow-up care coverage through the initial two months of 2016 only.

City of La Crosse Schedule of Benefits

Effective 1/1/17 - Employees Represented by LPPNSA & LPPSA and Employees Covered Under the Employee Handbook & Library

The following is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan document to ensure you understand the complete benefit(s).

Provision	In Network	Out-of-network
Annual deductible	$400 per Covered Person per year; not to exceed $1,200 per Family Unit.	$800 per Covered Person per Year with no Family Unit maximum.
	Deductibles for in network and Out-of-network do not cross apply. Any fixed-dollar co-pays are applied to the amount of allowable expense before the annual deductible. The deductible amount is not satisfied or lowered by any fixed-dollar co-pay amounts, any amounts exceeding the fixed-dollar and fixed-visit limits, excluded items, any amounts exceeding UCR when Out of Network or outpatient prescription drug costs.	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is $600 per Covered Person not to exceed $1,800 per Family Unit. Once this maximum is met, the plan pays 100% (co-pay and fixed dollar or visit limits, when applicable, would still pertain).	Plan generally pays 70% following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	$7,150 Individual / $14,300 Family Deductible, co-insurance, co-payments & Rx drug co-payments incurred in network are included.	No Out of Pocket Maximum
Usual, Customary, & Reasonable (UCR) fee limit	UCR does not apply to In Network charges.	UCR applies, Except as noted.
Pre-certification	Pre-certification is recommended for inpatient confinement, outpatient surgeries performed in outpatient hospital or surgical center, therapy services for more than five visits per Year, durable medical equipment, home health care, chiropractic care for more than 13 visits per Calendar Year, outpatient mental illness or chemical dependency for more than five visits per Calendar Year, immunizations for respiratory syncytial virus (RSV), dental restorative services, oral surgery, TMJ or other procedures as otherwise specified.	

Covered Benefit	In Network	Out-of-network
Neighborhood Family Clinics	Plan pays 100% of billed charges for eligible services under the Plan (as defined in the Master Plan Document). There is **no cost** to the member (not subject to deductible, co-pay or co-insurance). Charges for covered services will be billed by the Neighborhood Family Clinic directly to the Plan for payment.	
Professional Ambulance	Plan pays 90% following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*	Plan pays 90% of billed charges following the **in-network** deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% of UCR charges following the deductible when medically necessary for the conditions as outlined below.
	Treatment of Autism, Asperger Syndrome and Pervasive Development Disorder if treatment is recommended by an appropriate provider in accordance with the terms and conditions and limitations of Wis. Stat 632.895(12m). Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.	
Chiropractic	Plan pays 90% following $20 co-pay per daily visit and/or exam and deductible *(Maintenance Services are excluded).*	Plan pays 90% of UCR charges following $25 co-pay per daily visit and/or exam and deductible *(No Medical Necessity standard).* **Limited to 18 out-of-network visits per calendar year.**
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.

Covered Benefit	In Network	Out-of-network
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% of UCR charges following the deductible. Prior authorization recommended.
Dental Preventive or Diagnostic Services	No benefits except to the extent the Plan provides coverage for diagnostic services required for allowable types of dental and TMJ services stated below.	
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit and/or exam following the **in-network** deductible. Precertification notice recommended.
	Restorative services limited to repair or replacement of a natural tooth injured by blunt external force, other than chewing, within six months of such injury. Dental or oral surgery limited to 15 specific types of procedures and surgical TMJ services.	
Dental Restorative Services – Major (When Functionally Necessary)	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit or exam and the **in-network** deductible. Precertification notice recommended.
	Limited to simple non-cutting extraction of a natural erupted tooth and the initial replacement with an artificial tooth, when necessary (including initial partial dentures or bridgework).	
Diagnostic x-ray and lab or Non-PPACA Preventive x-ray and lab (Non-Hospital)	Plan pays 90% following the deductible.	Plan pays 70% of UCR charges following the deductible.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following $75 co-pay and deductible. Copay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% of billed charges following $75 co-pay and **in-network** deductible.. Copay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% of UCR charges following the deductible when medically necessary according to the below time frames and age guidelines.
	Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per child, per ear every three (3) years.	
Home Health Care	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 40 visits per Covered Person per Calendar Year combined for in network and out-of-network charges.	

Covered Benefit	In Network	Out-of-network
Hospice Care	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 180 daily visits per person per lifetime combined for in network and out-of-network charges.	
Hospital-Inpatient (Room & Board)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. Precertification notice recommended.
Hospital Outpatient (including diagnostic x-ray, lab tests and screenings)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the **in-network** deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following $20 co-pay per visit or exam and deductible. *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Services for emergency care are covered at 90% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. *(Maintenance services excluded)* Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following $20 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA)	Plan pays 100% (no co-pay or deductible).	Plan pays 70% of UCR charges following $25 co-pay and deductible.
	Includes but is not limited to: • Routine Physical Exam (one per Calendar Year) Well baby exams up to age 2 • Routine Gynecological Exam • Specific Immunizations • Routine Colonoscopy • Routine Sigmoidoscopy • Routine Mammogram • Routine Cholesterol or glucose screening (when not tied to a Diagnosis) *(See "Preventive Benefits Covered Under PPACA" handout for details or contact Plan Supervisor)*	
Physician	Plan pays 90% following $20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Applies to out of network Urgent Care visits within the state of WI For Urgent Care visits outside of the state of WI: Plan pays 90% following a $75 co-pay per visit or exam and in-network deductible. For Emergency In-Patient services, after a $20 co-pay per visit or exam and in-network deductible the Plan pays 90% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
	Co-pays waived for x-ray and lab including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	
Skilled Nursing Facility	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 60 days per Covered Person per Calendar Year combined for in network and out-of-network charges.	
Surgeon	Plan pays 90% following $20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.
	Co-pay waived for x-ray and lab technical and professional physician testing services (interpretive services of pathologists and radiologists), and anesthesiologist services. Precertification notice recommended for surgery when performed outside of a physician's office (other than diagnostic endoscopies such as colonoscopy).	
Therapy Services for Disability (Non-Physician) Physical, occupational &speech therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II	Plan pays 90% following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.
Vision Exam - Routine	Following a $10 co-pay per visit or exam and deductible, the Plan pays 90% up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.	Following a $10 co-pay per visit or exam and **in network deductible**, the Plan pays 70% of UCR charges up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% of the billed amounts not to exceed the PREVAILING FEE level for such type of service after application of co-pay amounts and deductible. Retirees and surviving spouses/dependents of retirees whose permanent residence is in the state of Wisconsin must see in network providers to be considered in network participants.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
(*Formulary* Applies)

IN NETWORK RETAIL CO-PAYMENT STRUCTURE **Plan deductible and co-insurance do not apply to the Prescription Drug Benefits**	
Generic medication co-payment per formulary prescription (including formulary insulin and diabetic supplies)	$10 for up to 30 day supply
Brand name medication co-payment per formulary prescription	$25 for up to 30 day supply
Speciality medication per formulary prescription (obtained through a Specialty Pharmacy)	$50 for up to a 30 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $50 for each 30-day supply, unless such brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	
MAIL ORDER CO-PAYMENT STRUCTURE (Mandatory Mail-Order of Maintenance Drugs)	
Generic maintenance medication co-payment per formulary prescription (including formulary insulin & diabetic supplies)	$20 for up to 90 day supply
Brand name maintenance medication co-payment per prescription	$50 for up to 90 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $100 for each 90-day supply, unless such formulary brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	

Notes:

This Schedule of Prescription Drug Benefits is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan Document to ensure you understand the complete benefits.

There is a maximum out of pocket (MOOP) of $7,150 Individual / $14,300 Family which includes Prescription drug co-payments and the medical benefit plan deductible, co-insurance, co-payments (when applicable) when incurred in network.
When a prescription is covered for a chronic medical condition, a covered person is allowed an initial trial period at a retail store (for up to a two (2) 30-day supplies) to confirm the drugs compatibility and effectiveness. Thereafter coverage for designated maintenance type drugs is limited to such home delivery method (including oral birth control, but does not apply to insulin or diabetic supplies).

Precertification (prior authorization) may be required for certain types of medications.

Out-of-Network prescription drugs are generally NOT covered. However, coverage may be available if: a) an allowable specialty drug is not available from a Network and is therefore obtained Out-of-network or b) in connection with emergency services when it is not reasonable to obtain from a Network pharmacy. Such Out-of-network claims must be paid by the covered participant at the point of service and then submitted by the covered participant to the prescription drug *Plan Supervisor* for reimbursement.

Excluded drugs *(Refer to the Prescription Drug Exclusion Section for a complete list of exclusions)***:**

a. for sexual dysfunction (other than related to organic disease or directly caused by prior allowable surgery)
b. for infertility
c. for services determined to be experimental or not of established medical value, and
d. for which a comparable over-the-counter drug is available (such as nutritional supplements and when the FDA ends the status of requiring a prescription for a drug)

(Schedule of Benefits Revised 1/1/2017)

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City of La Crosse Schedule of Benefits

Effective 1/1/17- IAFF Local #127 Active Pre-7/1/11 Hires & Post 1/6/12 Retirees

The following is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan document to ensure you understand the complete benefit(s).

Provision	In Network	Out-of-network
Annual deductible	$2,500 per Covered Person; not to exceed $7,500 per Family Unit.	
	Deductibles for in network and Out-of-network cross apply. Any fixed-dollar co-pays are applied to the amount of allowable expense before the annual deductible. The deductible amount is not satisfied or lowered by any fixed-dollar co-pay amounts, any amounts exceeding the fixed-dollar and fixed-visit limits, excluded items, any amounts exceeding UCR when Out of Network or outpatient prescription drug costs.	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is $600 per Covered Person not to exceed $1,800 per Family Unit. Once this maximum is met, the plan pays 100% (co-pay and fixed dollar or visit limits, when applicable, would still pertain).	Plan generally pays 70%, following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	$7,150 Individual / $14,300 Family Deductible, co-insurance, co-payments & Rx drug co-payments incurred in network are included.	No Out of Pocket Maximum
Usual, Customary, & Reasonable (UCR) fee limit	UCR does not apply to In Network charges.	UCR applies, Except as noted.
Pre-certification	Pre-certification is recommended for inpatient confinement, outpatient surgeries performed in outpatient hospital or surgical center, therapy services for more than five visits per Year, durable medical equipment, home health care, chiropractic care for more than 13 visits per Calendar Year, outpatient mental illness or chemical dependency for more than five visits per Calendar Year, immunizations for respiratory syncytial virus (RSV), dental restorative services, oral surgery, TMJ or other procedures as otherwise specified.	

Covered Benefit	In Network	Out-of-network
Neighborhood Family Clinics	Plan pays 100% of billed charges for eligible services under the Plan (as defined in the Master Plan Document). There is **no cost** to the member (not subject to deductible, co-pay or co-insurance). Charges for covered services will be billed by the Neighborhood Family Clinic directly to the Plan for payment.	
Professional Ambulance	Plan pays 90% following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*	Plan pays 90% of billed charges following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% of UCR charges following the deductible when medically necessary for the conditions as outlined below.
	Treatment of Autism, Asperger Syndrome and Pervasive Development Disorder if treatment is recommended by an appropriate provider in accordance with the terms and conditions and limitations of Wis. Stat 632.895(12m). Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.	
Chiropractic	Plan pays 90% following $20 co-pay per daily visit and/or exam and deductible *(Maintenance Services are excluded).*	Plan pays 70% of UCR charges following $25 co-pay per daily visit and/or exam and deductible *(No Medical Necessity standard).* **Limited to 18 out-of-network visits per calendar year.**
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.

Covered Benefit	In Network	Out-of-network
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% of UCR charges following deductible. Prior authorization recommended.
Dental Preventive or Diagnostic Services	No benefits except to the extent the Plan provides coverage for diagnostic services required for allowable types of dental and TMJ services stated below.	
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit or exam and deductible. Precertification notice recommended.
	Restorative services limited to repair or replacement of a natural tooth injured by blunt external force, other than chewing, within six months of such injury. Dental or oral surgery limited to 15 specific types of procedures and surgical TMJ services.	
Dental Restorative Services – Major (When Functionally Necessary)	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit or exam and deductible. Precertification notice recommended.
	Limited to simple non-cutting extraction of a natural erupted tooth and the initial replacement with an artificial tooth, when necessary (including initial partial dentures or bridgework).	
Diagnostic x-ray and lab or Non-PPACA Preventive x-ray and lab (Non-Hospital)	Plan pays 90% following the deductible.	Plan pays 70% of UCR charges following the deductible.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following $75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% of billed charges following $75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% of UCR charges following the deductible when medically necessary according to the below time frames and age guidelines.
	Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per child, per ear every three (3) years.	
Home Health Care	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 40 visits per Covered Person per Calendar Year combined for in network and out-of-network charges.	

Covered Benefit	In Network	Out-of-network
Hospice Care	Plan pays 90% following the deductible Precertification notice recommended	Plan pays 70% of UCR charges following the deductible Precertification notice recommended
	Maximum benefit of 180 daily visits per person per lifetime combined for in network and out-of-network charges	
Hospital-Inpatient (Room & Board)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. Precertification notice recommended.
Hospital Outpatient (including diagnostic x-ray, lab tests and screenings)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following $20 co-pay per visit or exam and the deductible. *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following $25 co-pay per visit or exam and the deductible. Services for emergency care are covered at 90% of billed charges after the deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. *(Maintenance services excluded)* Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following $20 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA also known as the Affordable Care Act)	Plan pays 100% (no co-pay or deductible).	Plan pays 70% of UCR charges following $25 co-pay and deductible.
	Includes but is not limited to: • Routine Physical Exam (one per Calendar Year) • Well baby exams up to age 2 • Routine Gynecological Exam • Specific Immunizations • Routine Colonoscopy • Routine Sigmoidoscopy • Routine Mammogram • Routine Cholesterol or glucose screening (when not tied to a Diagnosis) *(See "Preventive Benefits Covered Under ACA" handout for details or contact Plan Supervisor)*	
Physician	Plan pays 90% following $20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Applies to out of network Urgent Care visits within the state of WI For Urgent Care visits outside of the state of WI: Plan pays 90% following a $75 co-pay per visit or exam and deductible. For Emergency In-Patient services, after a $20 co-pay per visit or exam and deductible the Plan pays 90% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
	Co-pays waived for x-ray and lab including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	
Skilled Nursing Facility	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 60 days per Covered Person per Calendar Year combined for in network and out-of-network charges.	
Surgeon	Plan pays 90% following $20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible (Limited to 18 service visits per year for Out-of-Network).
	Co-pay waived for x-ray and lab technical and professional physician testing services (interpretive services of pathologists and radiologists), and anesthesiologist services. Precertification notice recommended for surgery when performed outside of a physician's office (other than diagnostic endoscopies such as colonoscopy).	
Therapy Services for Disability (Non-Physician) **Physical, occupational & speech therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II**	Plan pays 90% following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.
Vision Exam - Routine	Following a $10 co-pay per visit or exam and deductible, the Plan pays 90% up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exam for children under age 19.	Following a $10 co-pay per visit or exam and deductible, the Plan pays 70% of UCR charges up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% of the billed amounts not to exceed the PREVAILING FEE level for such type of service after application of co-pay amounts and deductible. Retirees and surviving spouses/dependents of retirees whose permanent residence is in the state of Wisconsin must see in network providers to be considered in network participants.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
(*Formulary* Applies)

IN NETWORK RETAIL CO-PAYMENT STRUCTURE **Plan deductible and co-insurance do not apply to the Prescription Drug Benefits**	
Generic medication co-payment per formulary prescription (including formulary insulin and diabetic supplies)	$10 for up to 30 day supply
Brand name medication co-payment per formulary prescription	$25 for up to 30 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $50 for each 30-day supply, unless such brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	
MAIL ORDER CO-PAYMENT STRUCTURE (Mandatory Mail-Order of Maintenance Drugs)	
Generic maintenance medication co-payment per formulary prescription (including formulary insulin & diabetic supplies)	$20 for up to 90 day supply
Brand name maintenance medication co-payment per prescription	$50 for up to 90 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $100 for each 90-day supply, unless such formulary brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	

Notes:

This Schedule of Prescription Drug Benefits is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan Document to ensure you understand the complete benefits.

There is a maximum out of pocket (MOOP) of $7,150 Individual / $14,300 Family which includes Prescription drug co-payments and the medical benefit plan deductible, co-insurance, co-payments (when applicable) when incurred in network.

When a prescription is covered for a chronic medical condition, a covered person is allowed an initial trial period at a retail store (for up to a two (2) 30-day supplies) to confirm the drugs compatibility and effectiveness. Thereafter coverage for designated maintenance type drugs is limited to such home delivery method (including oral birth control, but does not apply to insulin or diabetic supplies).

Precertification (prior authorization) may be required for certain types of medications.

Out-of-Network prescription drugs are generally NOT covered. However, coverage may be available if: a) an allowable specialty drug is not available from a Network and is therefore obtained Out-of-network or b) in connection with emergency services when it is not reasonable to obtain from a Network pharmacy. Such Out-of-network claims must be paid by the covered participant at the point of service and then submitted by the covered participant to the prescription drug *Plan Supervisor* for reimbursement.

Excluded drugs *(Refer to the Prescription Drug Exclusion Section for a complete list of exclusions)***:**

a. for sexual dysfunction (other than related to organic disease or directly caused by prior allowable surgery)
b. for infertility
c. for services determined to be experimental or not of established medical value, and
d. for which a comparable over-the-counter drug is available (such as nutritional supplements and when the FDA ends the status of requiring a prescription for a drug)

(Schedule of Benefits Revised 1/1/2017)

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City of La Crosse Schedule of Benefits

Effective 1/1/17 - IAFF Local #127 Employees Hired on/after 7/1/11 & Pre-1/6/12 IAFF Retirees

The following is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan document to ensure you understand the complete benefit(s).

Provision	In Network	Out-of-network
Annual deductible	$400 per Covered Person per year; not to exceed $1,200 per Family Unit.	$800 per Covered Person per Year with no Family Unit maximum.
	Deductibles for In network and Out-of-network do not cross apply. Any fixed-dollar co-pays are applied to the amount of allowable expense before the annual deductible. The deductible amount is not satisfied or lowered by any fixed-dollar co-pay amounts, any amounts exceeding the fixed-dollar and fixed-visit limits, excluded items, any amounts exceeding UCR when Out of Network or outpatient prescription drug costs.	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is $600 per Covered Person not to exceed $1,800 per Family Unit. Once this maximum is met, the plan pays 100% (co-pay and fixed dollar or visit limits, when applicable, would still pertain).	Plan generally pays 70%, following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	$7,150 Individual / $14,300 Family Deductible, co-insurance, co-payments & Rx drug co-payments incurred in network are included.	No Out of Pocket Maximum
Usual, Customary, & Reasonable (UCR) fee limit	UCR does not apply to In Network charges.	UCR applies, Except as noted.
Pre-certification	Pre-certification is recommended for inpatient confinement, outpatient surgeries performed in outpatient hospital or surgical center, therapy services for more than five visits per Year, durable medical equipment, home health care, chiropractic care for more than 13 visits per Calendar Year, outpatient mental illness or chemical dependency for more than five visits per Calendar Year, immunizations for respiratory syncytial virus (RSV), dental restorative services, oral surgery, TMJ or other procedures as otherwise specified.	

Covered Benefit	In Network	Out-of-network
Neighborhood Family Clinics	Plan pays 100% of billed charges for eligible services under the Plan (as defined in the Master Plan Document). There is **no cost** to the member (not subject to deductible, co-pay or co-insurance). Charges for covered services will be billed by the Neighborhood Family Clinic directly to the Plan for payment.	
Professional Ambulance	Plan pays 90% following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*	Plan pays 90% of billed charges following the in network deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% of UCR charges following the deductible when medically necessary for the conditions as outlined below.
	Treatment of Autism, Asperger Syndrome and Pervasive Development Disorder if treatment is recommended by an appropriate provider in accordance with the terms and conditions and limitations of Wis. Stat 632.895(12m). Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.	
Chiropractic	Plan pays 90% following $20 co-pay per daily visit and/or exam and deductible *(Maintenance Services are excluded).*	Plan pays 70% of UCR charges following $25 co-pay per daily visit and/or exam and deductible *(No Medical Necessity standard).* **Limited to 18 out-of-network visits per calendar year.**
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.

Covered Benefit	In Network	Out-of-network
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% of UCR charges following deductible. Prior authorization recommended.
Dental Preventive or Diagnostic Services	No benefits except to the extent the Plan provides coverage for diagnostic services required for allowable types of dental and TMJ services stated below.	
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit or exam and in network deductible. Precertification notice recommended.
	Restorative services limited to repair or replacement of a natural tooth injured by blunt external force, other than chewing, within six months of such injury. Dental or oral surgery limited to 15 specific types of procedures and surgical TMJ services.	
Dental Restorative Services – Major (When Functionally Necessary)	Plan pays 90% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following $20 co-pay per visit or exam and in network deductible. Precertification notice recommended.
	Limited to simple non-cutting extraction of a natural erupted tooth and the initial replacement with an artificial tooth, when necessary (including initial partial dentures or bridgework).	
Diagnostic x-ray and lab or Non-PPACA Preventive x-ray and lab (Non-Hospital)	Plan pays 90% following the deductible.	Plan pays 70% of UCR charges following the deductible.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following $75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% of billed charges following $75 co-pay and the in network deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% of UCR charges following the deductible when medically necessary according to the below time frames and age guidelines.
	Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per child, per ear every three (3) years.	
Home Health Care	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 40 visits per Covered Person per Calendar Year combined for in network and out-of-network charges.	

Covered Benefit	In Network	Out-of-network
Hospice Care	Plan pays 90% following the deductible Precertification notice recommended	Plan pays 70% of UCR charges following the deductible Precertification notice recommended
	Maximum benefit of 180 daily visits per person per lifetime combined for in network and out-of-network charges	
Hospital-Inpatient (Room & Board)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the in network deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. Precertification notice recommended.
Hospital Outpatient (including diagnostic x-ray, lab tests and screenings)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the in network deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following $20 co-pay per visit or exam and the deductible. *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following $25 co-pay per visit or exam and the deductible. Services for emergency care are covered at 90% of billed charges after the in network deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. *(Maintenance services excluded)* Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following $20 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA also known as Affordable Care Act)	Plan pays 100% (no co-pay or deductible).	Plan pays 70% of UCR charges following $25 co-pay and deductible.
	Includes but is not limited to: • Routine Physical Exam (one per Calendar Year) • Well baby exams up to age 2 • Routine Gynecological Exam • Specific Immunizations • Routine Colonoscopy • Routine Sigmoidoscopy • Routine Mammogram • Routine Cholesterol or glucose screening (when not tied to a Diagnosis) *(See "Preventive Benefits Covered Under ACA" handout for details or contact Plan Supervisor)*	
Physician	Plan pays 90% following $20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% of UCR charges following $25 co-pay per visit or exam and deductible. Applies to out of network Urgent Care visits within the state of WI For Urgent Care visits outside of the state of WI: Plan pays 90% following a $75 co-pay per visit or exam and in-network deductible. For Emergency In-Patient services, after a $20 co-pay per visit or exam and in network deductible the Plan pays 90% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
	Co-pays waived for x-ray and lab including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	
Skilled Nursing Facility	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 60 days per Covered Person per Calendar Year combined for in network and out-of-network charges.	
Surgeon	Plan pays 90% following $20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 70% of UCR charges following $25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible (Limited to 18 service visits per year for Out-of-Network).
	Co-pay waived for x-ray and lab technical and professional physician testing services (interpretive services of pathologists and radiologists), and anesthesiologist services. Precertification notice recommended for surgery when performed outside of a physician's office (other than diagnostic endoscopies such as colonoscopy).	
Therapy Services for Disability (Non-Physician) **Physical, occupational & speech therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II**	Plan pays 90% following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.
Vision Exam - Routine	Following a $10 co-pay per visit or exam and deductible, the Plan pays 90% up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exam for children under age 19.	Following a $10 co-pay per visit or exam and in network deductible, the Plan pays 70% of UCR charges up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% of the billed amounts not to exceed the PREVAILING FEE level for such type of service after application of co-pay amounts and deductible. Retirees and surviving spouses/dependents of retirees whose permanent residence is in the state of Wisconsin must see in network providers to be considered in network participants.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
(*Formulary* Applies)

IN NETWORK RETAIL CO-PAYMENT STRUCTURE **Plan deductible and co-insurance do not apply to the Prescription Drug Benefits**	
Generic medication co-payment per formulary prescription (including formulary insulin and diabetic supplies)	$10 for up to 30 day supply
Brand name medication co-payment per formulary prescription	$25 for up to 30 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $50 for each 30-day supply, unless such brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	
MAIL ORDER CO-PAYMENT STRUCTURE (Mandatory Mail-Order of Maintenance Drugs)	
Generic maintenance medication co-payment per formulary prescription (including formulary insulin & diabetic supplies)	$20 for up to 90 day supply
Brand name maintenance medication co-payment per prescription	$50 for up to 90 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $100 for each 90-day supply, unless such formulary brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	

Notes:

This Schedule of Prescription Drug Benefits is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan Document to ensure you understand the complete benefits.

There is a maximum out of pocket (MOOP) of $7,150 Individual / $14,300 Family which includes Prescription drug co-payments and the medical benefit plan deductible, co-insurance, co-payments (when applicable) when incurred in network.

When a prescription is covered for a chronic medical condition, a covered person is allowed an initial trial period at a retail store (for up to a two (2) 30-day supplies) to confirm the drugs compatibility and effectiveness. Thereafter coverage for designated maintenance type drugs is limited to such home delivery method (including oral birth control, but does not apply to insulin or diabetic supplies).

Precertification (prior authorization) may be required for certain types of medications.

Out-of-Network prescription drugs are generally NOT covered. However, coverage may be available if: a) an allowable specialty drug is not available from a Network and is therefore obtained Out-of-network or b) in connection with emergency services when it is not reasonable to obtain from a Network pharmacy. Such Out-of-network claims must be paid by the covered participant at the point of service and then submitted by the covered participant to the prescription drug *Plan Supervisor* for reimbursement.

Excluded drugs *(Refer to the Prescription Drug Exclusion Section for a complete list of exclusions)***:**

a. for sexual dysfunction (other than related to organic disease or directly caused by prior allowable surgery)
b. for infertility
c. for services determined to be experimental or not of established medical value, and
d. for which a comparable over-the-counter drug is available (such as nutritional supplements and when the FDA ends the status of requiring a prescription for a drug)

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City of La Crosse Schedule of Benefits
Effective 1/1/17
ATU Local #519

The following is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan document to ensure you understand the complete benefit(s).

Provision	In Network	Out-of-network
Annual deductible	$275 per Covered Person per year; not to exceed $825 per Family Unit.	$600 per Covered Person per Year with no Family Unit maximum.
	Deductibles for in network and Out-of-network do not cross apply. Any fixed-dollar co-pays are applied to the amount of allowable expense before the annual deductible. The deductible amount is not satisfied or lowered by any fixed-dollar co-pay amounts, any amounts exceeding the fixed-dollar and fixed-visit limits, excluded items, any amounts exceeding UCR when Out of Network or outpatient prescription drug costs.	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 100%, following the deductible, EXCEPT as otherwise stated.	Plan generally pays 80% following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	$7,150 Individual / $14,300 Family Deductible, co-insurance, co-payments & Rx drug co-payments incurred in network are included.	No Out of Pocket Maximum
Usual, Customary, & Reasonable (UCR) fee limit	UCR does not apply to In Network charges.	UCR applies, Except as noted.
Pre-certification	Pre-certification is recommended for inpatient confinement, outpatient surgeries performed in outpatient hospital or surgical center, therapy services for more than five visits per Year, durable medical equipment, home health care, chiropractic care for more than 13 visits per Calendar Year, outpatient mental illness or chemical dependency for more than five visits per Calendar Year, immunizations for respiratory syncytial virus (RSV), dental restorative services, oral surgery, TMJ or other procedures as otherwise specified.	

Covered Benefit	In Network	Out-of-network
Professional Ambulance	Plan pays 100% following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*	Plan pays 100% of billed charges following the **in-network** deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*
Autism	Plan pays 100% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 80% of UCR charges following the deductible when medically necessary for the conditions as outlined below.
	Treatment of Autism, Asperger Syndrome and Pervasive Development Disorder if treatment is recommended by an appropriate provider in accordance with the terms and conditions and limitations of Wis. Stat 632.895(12m). Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.	
Chiropractic	Plan pays 100% following $20 co-pay per daily visit and/or exam and deductible *(Maintenance Services are excluded).*	Plan pays 100% of UCR charges following $25 co-pay per daily visit and/or exam and deductible *(No Medical Necessity standard).* **Limited to 18 out-of-network visits per calendar year.**
Convenience Clinics	Plan pays 100%, no co-pay or deductible applies to visit	Plan pays 80%, no co-pay or deductible applies to visit
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 100% following deductible. Prior authorization recommended.	Plan pays 80% of UCR charges following the deductible. Prior authorization recommended.
Dental Preventive or Diagnostic Services	No benefits except to the extent the Plan provides coverage for diagnostic services required for allowable types of dental and TMJ services stated below.	

Covered Benefit	In Network	Out-of-network
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 100% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 100% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 100% of UCR charges following $20 co-pay per visit and/or exam following the **in-network** deductible. Precertification notice recommended.
	Restorative services limited to repair or replacement of a natural tooth injured by blunt external force, other than chewing, within six months of such injury. Dental or oral surgery limited to 15 specific types of procedures and surgical TMJ services.	
Dental Restorative Services – Major (When Functionally Necessary)	Plan pays 80% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 80% of UCR charges following $20 co-pay per visit or exam and the **in-network** deductible. Precertification notice recommended.
	Limited to simple non-cutting extraction of a natural erupted tooth and the initial replacement with an artificial tooth, when necessary (including initial partial dentures or bridgework).	
Diagnostic x-ray and lab or Non-PPACA Preventive x-ray and lab (Non-Hospital)	Plan pays 100% following the deductible.	Plan pays 80% of UCR charges following the deductible. Lab services for emergency care are covered at 100% of billed charges following deductible for services originating from hospital outpatient emergency department until such discharge.
Durable Medical Equipment	Plan pays 100% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 100% following $75 co-pay and deductible. Copay is waived when admitted as an Inpatient within 24 hours.	Plan pays 100% of billed charges following $75 co-pay and **in-network** deductible.. Copay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 100% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 80% of UCR charges following the deductible when medically necessary according to the below time frames and age guidelines.
	Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per child, per ear every three (3) years.	
Home Health Care	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 40 visits per Covered Person per Calendar Year combined for in network and out-of-network charges.	

Covered Benefit	In Network	Out-of-network
Hospice Care	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 180 daily visits per person per lifetime combined for in network and out-of-network charges.	
Hospital-Inpatient (Room & Board)	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. Precertification notice recommended.
Hospital Outpatient (including diagnostic x-ray, lab tests and screenings)	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 100% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 100% following $20 co-pay per visit or exam and deductible. *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. *(Maintenance services excluded)* Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 100% following $20 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA)	Plan pays 100% (no co-pay or deductible).	Plan pays 80% of UCR charges following $25* co-pay and deductible.
	Includes but is not limited to: • Routine Physical Exam (one per Calendar Year) Well baby exams up to age 2 • Routine Gynecological Exam • Specific Immunizations • Routine Colonoscopy • Routine Sigmoidoscopy • Routine Mammogram • Routine Cholesterol or glucose screening (when not tied to a Diagnosis) *(See "Preventive Benefits Covered Under PPACA" handout for details or contact Plan Supervisor)* *Out of network Co-pay waived for one routine physical exam or school required exam per Year, one gynecological exam per Year, well-baby exams up to age 2, routine immunizations and vaccines, injectable birth control, x-ray and lab and technical and professional physician testing services (interpretive services of pathologists and radiologists) including screenings such as mammography, pap smear, colonoscopy and prostate screenings.	
Physician	Plan pays 100% following $20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Applies to out of network Urgent Care visits within the state of WI For Urgent Care visits outside of the state of WI: Plan pays 100% following a $75 co-pay per visit or exam and in-network deductible. For Emergency In-Patient services, after a $20 co-pay per visit or exam and in-network deductible the Plan pays 100% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
	Co-pays waived for x-ray and lab including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	
Skilled Nursing Facility	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 60 days per Covered Person per Calendar Year combined for in network and out-of-network charges.	
Surgeon	Plan pays 100% following $20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.
	Co-pay waived for x-ray and lab technical and professional physician testing services (interpretive services of pathologists and radiologists), and anesthesiologist services. Precertification notice recommended for surgery when performed outside of a physician's office (other than diagnostic endoscopies such as colonoscopy).	
Therapy Services for Disability (Non-Physician) **Physical, occupational, speech, therapy, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II**	Plan pays 100% following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.
Vision Exam - Routine	Following a $10 co-pay per visit or exam and deductible, the Plan pays 100% up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.	Following a $10 co-pay per visit or exam and **in network deductible**, the Plan pays 80% of UCR charges up to an $80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The $80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 100% of the billed amounts not to exceed the PREVAILING FEE level for such type of service after application of co-pay amounts and deductible. Retirees and surviving spouses/dependents of retirees whose permanent residence is in the state of Wisconsin must see in network providers to be considered in network participants.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
(*Formulary* Applies)

IN NETWORK RETAIL CO-PAYMENT STRUCTURE **Plan deductible and co-insurance do not apply to the Prescription Drug Benefits**	
Generic medication co-payment per formulary prescription (including formulary insulin and diabetic supplies)	$10 for up to 30 day supply
Brand name medication co-payment per formulary prescription	$20 for up to 30 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $30 for each 30-day supply, unless such brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	
MAIL ORDER CO-PAYMENT STRUCTURE (Mandatory Mail-Order of Maintenance Drugs)	
Generic maintenance medication co-payment per formulary prescription (including formulary insulin & diabetic supplies)	$20 for up to 90 day supply
Brand name maintenance medication co-payment per prescription	$40 for up to 90 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $60 for each 90-day supply, unless such formulary brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	

Notes:

This Schedule of Prescription Drug Benefits is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan Document to ensure you understand the complete benefits.

There is a maximum out of pocket (MOOP) of $7,150 Individual / $14,300 Family which includes Prescription drug co-payments and the medical benefit plan deductible, co-insurance, co-payments (when applicable) when incurred in network.

When a prescription is covered for a chronic medical condition, a covered person is allowed an initial trial period at a retail store (for up to a two (2) 30-day supplies) to confirm the drugs compatibility and effectiveness. Thereafter coverage for designated maintenance type drugs is limited to such home delivery method (including oral birth control, but does not apply to insulin or diabetic supplies).

Precertification (prior authorization) may be required for certain types of medications.

Out-of-Network prescription drugs are generally NOT covered. However, coverage may be available if: a) an allowable specialty drug is not available from a Network and is therefore obtained Out-of-network or b) in connection with emergency services when it is not reasonable to obtain from a Network pharmacy. Such Out-of-network claims must be paid by the covered participant at the point of service and then submitted by the covered participant to the prescription drug *Plan Supervisor* for reimbursement.

Excluded drugs *(Refer to the Prescription Drug Exclusion Section for a complete list of exclusions)***:**

a. for sexual dysfunction (other than related to organic disease or directly caused by prior allowable surgery)
b. for infertility
c. for services determined to be experimental or not of established medical value, and
d. for which a comparable over-the-counter drug is available (such as nutritional supplements and when the FDA ends the status of requiring a prescription for a drug)