Aurora Accountable Care Network

Summary Plan Description

Medical options 1 and 2

January 1, 2013

Aurora Health Care®

At Aurora, we help people live well

For our caregivers

We strive to listen to and implement better ideas, recognize and reward contributions, offer competitive pay and benefits, and continue building a wide range of career opportunities. We pledge to explain business issues and strategies, to anticipate and respond to change, and to provide needed technology and information. We will use resources wisely, operate cost-effectively, and maintain a sound financial base so we will be able to make investments in the future – improving health care for all of us.

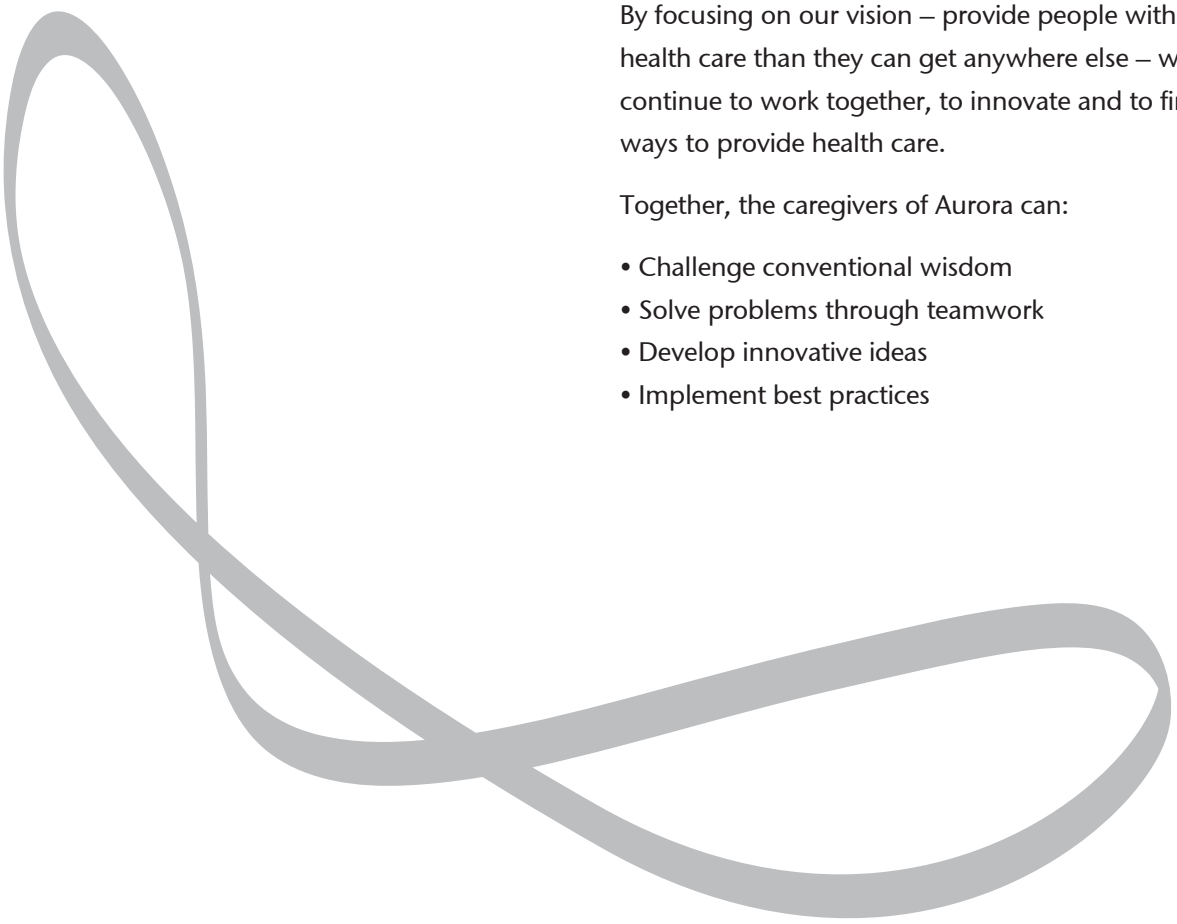
This is our purpose statement. It relates to those we treat, those who receive preventive care, and those we care for at the end of life. We help by listening to, partnering with and caring for patients, families and each other.

Aurora Health Care's strength stems from the teamwork and collaboration among our talented and diverse group of caregivers. Every day, each of us needs to use our knowledge, experience and creativity to find new ways of doing things.

By focusing on our vision – provide people with better health care than they can get anywhere else – we will continue to work together, to innovate and to find better ways to provide health care.

Together, the caregivers of Aurora can:

- Challenge conventional wisdom
- Solve problems through teamwork
- Develop innovative ideas
- Implement best practices



Dear Fellow Caregiver:

This medical plan summary is the current Summary Plan Description (SPD) for the Plan. Please set aside some time to read this information so you understand the benefits you may be able to receive. The purpose of this SPD is to explain the provisions of the Plan, participation requirements, how the Plan works, and how the Plan applies to you.

This information is provided to you even if you do not currently have the coverage since it is informative for future reference in case you enroll in the Plan. If you have any questions concerning the information in this Summary Plan Description, please feel free to contact your local human resources department.

Sincerely,

Carol Hadley
Sr. Director, Benefits

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Introduction

All of us appreciate the need for a medical benefits program. From time to time, even the healthiest individuals need medical assistance in the form of a prescription, routine office visit to a *physician*, treatment for an *injury* at an *emergency* room, or a lengthy *hospital* stay for a serious *illness*.

Aurora Health Care and its affiliates realize the need for quality medical coverage for its *employees* and, therefore, offer *you* and *your dependents* a comprehensive medical benefits program. The *plan* is designed to help *you* and Aurora Health Care control and manage health care costs.

This booklet is written in simple, easy-to-understand language. It is also the *plan* document. Words in italics are defined in the "Definitions" section near the end of this booklet. Benefits described in this document are effective January 1, 2013.

Aurora Health Care has prepared this booklet to help *you* and *your dependents* understand *your* (and *your dependent's)* medical benefits. Please read it carefully. *Your (*and *your dependent's)* benefits are affected by certain limitations and conditions that require *you* and *your dependent* to be a wise consumer of health services and to use only those services *you* and *your dependents* need. Also, benefits are not provided for certain kinds of treatments or services, even if *you* or *your dependent's health care provider* recommends them. Benefits are paid for *eligible expenses* incurred on the effective date of this *plan* and thereafter as long as *you* (or *your dependent*, as applicable) are covered under the *plan*. This booklet does not contain a provider list. A provider list can be obtained without charge through Aurora's iConnect.

As used in this document, the word *year* refers to the *benefit year*, which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time *you* or *your* eligible *dependents* participate in this *plan* or any other medical plan sponsored by Aurora Health Care or its affiliates.

The benefits described in this document are provided and funded by Aurora Health Care. UMR.administers the medical benefits of the *plan* and MedImpact Healthcare Systems, Inc. manages the *prescription drug* benefits of the *plan* for Aurora. UMR and MedImpact do not insure the benefits of the *plan*, and have no obligation or liability to provide benefits. When *you* have questions regarding the processing of *your* claim, Explanation of Benefits (EOB) statement, benefits, or membership, call or write:

For medical claims, excluding *prescription drugs*:

UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541
Toll free number: 1-800-860-5217

For prescription drugs:
MedImpact Healthcare Systems, Inc.
10680 Treena Street, Stop 5
San Diego, CA 92131
Toll Free Number: 1-800-788-2949

If *you* or *your dependents have* any questions about the benefits described in this booklet, contact *your* local human resources department.

You and *your dependent* may not rely on any oral statements about this *plan* that do not conform to the provisions and rules in this document, or to past administration of the *plan*.

Summary of Benefits

AACN Plan Option 1 & 2

	AACN OPTION 1		AACN OPTION 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual *Deductible*	$500 Individual $1,000 Employee + Child(ren), Employee + *Spouse*, and Family	$1,000 Individual $2,000 Employee + Child(ren), Employee + *Spouse*, and Family	$1,800 Single Plan $3,600 Employee + Child(ren), Employee + *Spouse*, and Family	$3,600 Single Plan $7,200 Employee + Child(ren), Employee + *Spouse*, and Family
	The deductible applies to each covered person. If coverage is not single, it must be met by two or more covered participants combined meeting the $1,000 in-network or the $2,000 out-of-network deductible,		The deductible is met by the first claims incurred during the year, no matter whom they are for. Therefore, If coverage is not single, one person could be responsible for the full deductible ($3,600 in-network or $7,200 out-of-network) amount if they are the first person to have claims for the year.	
Annual Out-of-Pocket Limit	$2,000 Individual $4,000 Employee + Child(ren), Employee + *Spouse*, or Family	$6,000 Individual $12,000 Employee + Child(ren), Employee + *Spouse*, or Family	$4,000 Single Plan $8,000 Employee + Child(ren), Employee + *Spouse*, or Family	$8,000 Single Plan $16,000 Employee + Child(ren), Employee + *Spouse*, or Family
	The out-of-pocket maximum applies to each covered person. If coverage is not single, it must be met by two or more covered participants combined meeting the $2,000 in-network or the $4,000out-of-network deductible.		The out-of-pocket maximum is met by the first claims incurred during the year, no matter whom they are for. Therefore, If coverage is not single, one person could be responsible for the full deductible ($8,000 in-network or $16,000,out-of-network) amount if they are the first person to have claims for the year.	

The *plan* pays the stated *co-insurance* percentage of covered charges of benefits up to the benefit maximum limitations as shown in the summary of benefits below. Please refer to the text for additional explanations on *plan* provisions, which may affect *your* benefits.

			Aurora Accountable Care Network Option 1				**Aurora Accountable Care Network Option 2**			
			In-Network		**Out-of-Network**		**In-Network**		**Out-of-Network**	
Description	**Deductible Applies**	**Additions, Limitations, Explanations**	***Plan* Pays Co Ins.**	***You* Pay Co Ins.**	***Plan* Pays Co Ins.**	***You* Pay Co Ins.**	***Plan* Pays Co Ins.**	***You* Pay Co Ins.**	***Plan* Pays Co Ins.**	***You* Pay Co Ins.**
Allergy Care	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Ambulance Services	Yes	All *medically necessary* charges are payable as an in-network benefit	85%	15%	Same as in-network		75%	25%	Same as in-network	
Diagnostic X-Ray Laboratory Services	Yes		85%	15%	55%	45%	75%	25%	55%	45%

			Aurora Accountable Care Network Option 1				Aurora Accountable Care Network Option 2			
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Description	**Deductible Applies**	**Additions, Limitations, Explanations**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**
Diet Counseling and Education	Yes	Some limitations apply	85%	15%	55%	45%	75%	25%	55%	45%
Durable Medical Equipment	Yes	Some limitations may apply. Contact UMR to verify benefits & medical necessity review requirements	85%	15%	55%	45%	75%	25%	55%	45%
Emergency Department Services (Life or Limb Threatening)	Yes	All life and limb threatening *emergency* services treated as in-network.	85%	15%	Same as in-network		75%	25%	Same as in-network	
Emergency Department Services (Non-life or Non-limb Threatening)	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Emergency Department Services	No	Additional co-pay for each visit (waived only if admitted to the hospital from ED). If life or limb threatening, out-of-network co-pay reduced to in-network level.		$100		$200		$100		$200
Home Health Care	Yes	Limited to 40 visits per *covered person* per *year*.	85%	15%	55%	45%	75%	25%	55%	45%
Home Hospice Care	Yes	Limited to 80 visits per *covered person* per *year*. Contact Aurora Medical Management to preauthorize.	85%	15%	55%	45%	75%	25%	55%	45%
Hospice *Inpatient*	Yes	Contact Aurora Medical	85%	15%	55%	45%	75%	25%	55%	45%

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Care		Management Team to preauthorize.								
Hospital Inpatient Care	Yes	Contact Aurora Medical Management Team to preauthorize.	85%	15%	55%	45%	75%	25%	55%	45%
Hospital Outpatient Care	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Medical Supplies Dispensed Through a Pharmacy	Yes	Not all medical supplies are covered by the *plan*	85%	15%	55%	45%	75%	25%	55%	45%
Mental Health/ Substance Use Services (*Inpatient*)	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Mental Health/ Substance Use Services (*Outpatient*)	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Occupational Therapy	Yes	60 visits combined limit per *covered person* per *year* for *outpatient* physical therapy, occupational therapy and speech therapy. Contact UMR to verify benefits & medical necessity review requirements.	85%	15%	55%	45%	75%	25%	55%	45%

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Physical Therapy	Yes	60 visits combined limit per *covered person* per *year* for *outpatient* physical therapy, occupational therapy and speech therapy. Contact UMR to verify benefits & medical necessity review requirements.	85%	15%	55%	45%	75%	25%	55%	45%
Physician Visits (In-Office or *Hospital*)	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Podiatry (Outpatient) Services	Yes	Maximum *plan* payment is $150 per *covered person* per *year once deductible is met for routine care only if diagnosed with peripheral vascular disease or diabetes.*	85%	15%	55%	45%	75%	25%	55%	45%
Prescription Drugs: Generic	Option 1: No Option 2: Yes	*You* pay flat co-pay of $7 per prescription In-network; $14 flat co-pay out-of-network.	Balance of claim	$7.00	Balance of claim	$14.00	Balance of claim	Once deduct-ible is met *you* pay $7.00	Balance of claim	Once deduct-ible is met *you* pay $14.00
Prescription Drugs: Brand Name Not all prescriptions are covered by the *plan*. In-Network dispensed through Aurora	Option 1: No Option 2: Yes	**Preferred brand** minimum $30, maximum $50 per prescription for a month supply. **Non-preferred** brand minimum $50, maximum $75. **Out-of-Network** *you* pay minimum $50, maximum $100	75% 60%	25% 40%	55% 40%	45% 60%	Once deduct-ible is met plan pays 75% Once deduc tible is met plan pays 60%	Once deduct-ible is met *you* pay 25% Once deduc tible is met *you pay* 40%	Once deduct-ible is met plan pays 55% Once deduct ible is met plan pays 40%	Once deduct-ible is met *you* pay 45% Once deduct ible is met *you* pay 60%

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Description	**Deduct-ible Applies**	**Additions, Limitations, Explanations**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**	***Plan*** **Pays Co Ins.**	***You*** **Pay Co Ins.**
pharmacy. Under AACN Opt 2, prescription drug costs are included in the plan's annual out-of-pocket limit. Once you meet AACN Opt 2. Plan's annual out of pocket limit your prescriptions are paid at 100%.		per prefer-red brand one-month supply. *You* pay minimum $75, maximum $100 per non-preferred brand one-month supply. Under AACN Opt 1, you pay a separate annual out of pocket in-network maximum of $2,000 per covered participant then the plan pays 100% of prescriptions.								
Prescription Drugs: ***Specialty*** Not all prescriptions are covered by the plan. Under AACN Opt 1 you pay a separate annual out of pocket in-network maximum of $2,000 per covered participant then the plan pays 100% of prescriptions. Under AANC Opt 2 prescription drug costs,	Option 1: No Option 2: Yes	**Preferred brand** minimum $30, maximum $50 per prescription for a one month supply. **Non-preferred** brand minimum $50, maximum $75 per prescription for a one month supply.. **Out-of-Network** Not covered under the plan; you are responsible for full cost. All Specialty drugs are limited to a 30-day supply per fill. In-Network Specialty Drugs	75% 60%	25% 40%	Not Covered Not Covered	Not Covered Not Covered	Once deduct-ible is met plan pays 75% Once deduc tible is met plan pays 60%	Once deduct-ible is met you pay 25% Once deduct-ible is met you pay 40%	Not Covered Not Covered	Not Covered Not Covered

			Aurora Accountable Care Network Option 1				Aurora Accountable Care Network Option 2			
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including Specialty Drugs, are subject to the deductible, and are included in the plan's annual out of pocket limit. Once you meet AACN Opt 2 plan annual out of pocket limit your prescriptions are paid at 100%.		are dispensed through Aurora Pharmacy or CommCare.								
Prescription Drugs – Contra-ceptives under PPACA	Option 1: No Option 2: Yes	**FDA approved only Out-of-Network** *you* pay minimum $50, maximum $100 per prefer-red brand one-month supply. *You* pay minimum $75, maximum $100 per non-preferred brand one-month supply.	100%	0%	55%	45%	100%	0%	Once deduct-ible is met plan pays 55% Once deduct ible is met plan pays 40%	Once deduct-ible is met *you* pay 45% Once deduct ible is met *you* pay 60%

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Preventive Care	No	Limited to one physical exam per covered person per year; other limitations are set forth in "What the Plan Covers" section	100%	N/A	Not Covered	Not Covered	100%	N/A	Not Covered	Not Covered
Skilled Nursing Facility Care	Yes	All *medically necessary* charges are considered at in-network level and are limited to 30 days per admission to a maximum of 100 days per *covered person* per *year*, must be admitted from *inpatient hospital* stay. Contact Aurora Medical Management Team to preauthorize.	85%	15%	N/A	N/A	75%	25%	N/A	N/A
Speech Therapy	Yes	60 visits combined limit per *covered person* per *year* for *outpatient* physical therapy, occupational therapy and speech therapy. Contact Aurora Medical Management Team to preauthorize.	85%	15%	55%	45%	75%	25%	55%	45%
Surgical Care or *Surgery* (*Inpatient* and *Outpatient*)	Yes		85%	15%	55%	45%	75%	25%	55%	45%
Urgent Care	Yes		85%	15%	55%	45%	75%	25%	55%	45%
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Vision Exam	Yes	One vision exam per *covered person* per *year*, covered in-network only.	85%	15%	Not Covered	Not Covered	75%	25%	Not Covered	Not Covered
Well-Child Care	No	Well childcare covered in-network only.	100%	0%	Not Covered	Not Covered	100%	0%	Not Covered	Not Covered
Well-Nursery Care	Yes	Well nursery care covered during initial *hospital* confinement.	85%	15%	55%	45%	75%	25%	55%	45%

Aurora Accountable Care Network (AACN) Covered Person's Rights and Responsibilities

Aurora Health Care is dedicated to providing quality medical coverage for its *employees* and their eligible *dependents*. Effective medical care requires a cooperative partnership among patients, *physicians* and other health care professionals. The Aurora Accountable Care Network *plan* places an emphasis on education, access, and appropriate utilization of available services. Participation in the *plan* includes certain rights and responsibilities, including the active management of *your* own personal medical care and that of *your dependents*.

As a *covered person* in the Aurora Accountable Care Network *plan*, *you* and *your dependent* have the right to:

- Be treated with respect, consideration and dignity.
- Be provided with information about the *plan*, its services and participating providers.
- Receive without charge a copy of the *plans* procedures governing qualified medical child support orders (QMCSOs) through *your* local human resources department.
- Receive information, in an understandable form, concerning *your (*or *your dependent's)* diagnosis, treatment and prognosis.
- Participate in decisions involving *your* (or *your dependent's)* care.
- Privacy and confidential treatment of all communications and records relating to *your* (or *your dependent's)* care.
- Share any concerns or suggestions regarding the care *you* and *your dependent* receive with Aurora Accountable Care Network.

As a *covered person* in the Aurora Accountable Care Network *plan*, you have the responsibility to:

- Provide complete information to *your health care provider* about *yourself*, or *your dependent,* and *your (*or *your dependent's)* health status.
- Follow the course of treatment recommended by *your* (or *your dependent's) health care provider*(s).
- Ask sufficient questions so that *you* or *your dependents understand* recommended treatment.
- Update *your dependent's* status on Employee Connection within 60 days of the change; for example, adding or removing *dependents*, changes in marital status, change of address, etc.
- Recognize the effect of lifestyle on *your* (or *your dependent's)* personal health and develop and maintain positive health practices such as good nutrition, adequate sleep and rest, exercise, and participation in

preventive and care management initiatives.

Aurora Accountable Care Network (AACN) Care Management Model

What is the Aurora Accountable Care Network Care Management Model?

Aurora Health Care wants to provide *you* and *your dependents* with a medical care benefit plan that financially protects *you* from significant medical care expenses and assures *you* of quality care. While part of increasing medical care costs result from new technology and important medical advances, another significant cause is the way health care services are used.

Aurora Health Care subscribes to a special medical care program known as the **Aurora Accountable Care Network Care Management Model** to identify and assist *you* and *your dependents* with medical conditions requiring extensive or long-term care. It is designed to help *you* and *your dependents* obtain the right care, at the right time, in the right place, and at the best possible cost.

It is based on Aurora Health Care's philosophy of care management; i.e., that the overall health of an *employee* population is improved through services that are coordinated, accessible, appropriate, understandable, comparable, and measurable. This means that *you* and *your dependents*, Aurora Health Care, and *your* provider all play active roles in the delivery and management of medical care. Of course, the *plan's* rules do not change the responsibility that rests with the attending *physician* and patient for all treatment decisions.

Special programs are available under the Care Management Model to help meet the unique needs of *you* and *your dependents*. They fall into the four distinct population segments as described in the chart below.

Available Programs	Population	Definition of Population
Aurora Teleservices	Well	Occasional self-limited *illness*
Care (Disease) Management	Chronic Disease	Moderate/mild chronic disease with complications.
Catastrophic Case Management	Catastrophic Disease	Single or multiple acute diseases requiring high cost interventions, severe trauma.
Community Based Case Management	Chronic Disease	Very unstable chronic disease or multiple chronic diseases.
Utilization Management	Episodic Disease	Occasional onset of disease, mild trauma, uncomplicated acute *illness*.

Aurora Teleservices

When *you* have a question about *your* health or need advice about a family member's health**,** Aurora Teleservices is available to help 24 hours a day, seven days a week. By calling **1-888-747-5380**, *you* can talk to an experienced, registered *nurse* for advice on everything from what to do about a persistent cough to *your* baby's sudden fever to *your* severe headaches. The Aurora Teleservices staff has an average of 16 years of nursing experience plus special training and access to reliable information on a complete range of medical situations. All calls to Aurora Teleservices are free and confidential.

Care (Disease) Management

You or a *dependent* may be suffering from a major *illness* associated with the chronic disease population segment. Care (Disease) Management is a series of special programs designed to help improve the health status and well-being of *you* or a *dependent* suffering from a major *illness*, and reduce hospitalization and *emergency* room costs. The goal of these programs is to provide: (a) integrated, patient/family-oriented and coordinated care for certain high prevalence, high cost, and impactable diagnoses, (b) guidelines for providers, patients, and families enabling *you* to become partners in health care decisions, and (c) a basis for measuring outcomes and comparing outcomes to best practice patterns.

Chronic Disease Care Management Programs are Available for:

- Asthma;
- Cholesterol management;
- Congestive heart failure; and
- Diabetes

If *you* or a *dependent* has any of the above medical conditions (diagnoses), *you* will be automatically enrolled in a Care Management program.

Catastrophic Case Management

Unfortunately, *you* or a *dependent* may end up in the catastrophic disease population segment because of an unstable disease or severe trauma. When this happens, AACN Catastrophic Case Management *Nurses* will work with *you*, *your* family, and care providers along the continuum of care to make sure the treatment *you* and *your dependent* receive is of the best quality.

Community Based Care Management

If *you* or a *dependent* has a very unstable chronic disease or multiple chronic diseases *you* or *your dependent* may be referred for Community Based Case Management. Community Based Case Management *nurses* work with *you* or *your dependent*, *your* family and *your* care providers to develop a coordinated plan of care in order to improve and maintain *your* or *your dependent's* health.

Utilization Management

AACN provides utilization management for *you* or a *dependent* suffering from an *illness* associated with the episodic disease population segment. It is designed to ensure that: (a) the medical care *you* and *your dependents* receive is managed appropriately, (b) *you* and *your dependents* are directed to the appropriate facilities for medical care, (c) the cost of care for *you* and *your dependents* is managed, (d) *you* and *your dependents'* relationship with *your* provider is nurtured to facilitate improvement in the process of care, and

(e) communication between *you*, *your dependents*, and *your* provider is increased at the local level. In short, when the above utilization management services are initiated by *you*, *your dependents* or *your* provider, significant cost savings result for *you*, *your dependents*, and Aurora.

Exception Review for Services Not Available In-Network

Exception Review is a program designed to help *you* and *your dependents* when *medically necessary* services (refer to *plan medically necessary/ medical necessity* definitions) are not available from a provider within the Aurora Accountable Care Network or cannot be delivered by an *in-network provider*. For medical claims, call the AACN Medical Management Team at 1-800-251-0838 and for Behavioral Health Claims call Aurora Behavioral Health Management Team at 1-800-236-3231. You may be able to avoid higher out-of-pocket costs typically associated with services provided by an *out-of-network provider*. The Medical Management Team or Behavioral Health Management Team will review your situation and work with your plan administrator to determine if out-of-network services should be covered at the in-network level.

Pre-Notification Elective *Hospital* Admission Pre-Notification

Regardless of whether care is provided in-network or out-of-network, pre-notification is requested for all non-emergency *hospital* admissions. Please call the AACN Medical Management Team at 1-800-251-0838 as soon as hospitalization or *inpatient surgery* has been scheduled, but no later than five days prior to the date of admission.

AACN's Medical Management Team screens scheduled admissions to ensure *your* (or *your dependent's)* condition/treatment warrants acute care confinement, *you* or *your dependent* are an eligible member, services for *you* (or *your dependent*) are covered under the *plan*, and the most appropriate setting is used for *your* (or *your dependent's*) service. The decision to cover *your (*or *your dependent's)* hospitalization would be based on *medical necessity*. Other options such as home health care and *outpatient surgery* should be used whenever medically appropriate.

Emergency *Hospital* Admission Notification

Regardless of whether care is provided in-network or out-of-network, notification is requested for all *emergency hospital* admissions. Please call the AACN Medical Management Team at 1-800-251-0838 within 24 hours of the occurrence or on the next regular business day if the admission occurs on a weekend or holiday.

Upon notification, the AACN Medical Management Team will screen *emergency* and unscheduled admissions within 24 hours of occurrence or the next regular business day following a weekend or holiday to ensure acute care confinement is *medically necessary*.

Inpatient Mental Health/Substance Use Services Admission Notification

Regardless of whether care is provided in-network or out-of-network, notification is requested for all inpatient mental health/substance use services. Please call the Aurora Health Care Employee Assistance Program (EAP) at 1-800-236-3231 within 24 hours of the occurrence or on the next regular business day if admission occurs on a weekend or holiday.

Pre-Notification of *Outpatient Hospital* Services and *Prescription Drugs*
Pre-notification is requested for certain outpatient diagnostic services, outpatient therapies, surgical procedures, and prescription drugs regardless of whether care is provided or the item is purchased in-network or out-of-network. The Summary of Benefits indicates which services and items are subject to pre-notification. A more detailed list of the services and items subject to pre-notification can be found on Employee Connection. To determine whether any of the above benefits is subject to pre-notification, please call the AACN Medical Management Team at 1-800-251-0838 as soon as the services, procedures, or prescriptions have been ordered, but no later than five days prior to the date of service.

Preventive Health

AACN's wellness philosophy is established on the assumption that healthy people are more likely to stay "well" if they receive a defined set of clinical preventive services at certain times based on their age and gender. Under the Care Management Model, *you* or *your dependent* may be notified by Aurora Care Management if *you* or *your dependent* haven't had the recommended preventive services.

Eligibility and Participation

Who is Eligible for Coverage

Employee

If *you* are a regular full-time or part-time *employee* assigned 40 or more hours per pay period, *you* and *your* eligible *dependent*(s) may participate in this *plan* and receive an *employer* contribution toward the cost of coverage. Student employees, interns or temporary employees are not eligible

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Dependent

Your eligible *dependent*(s) may also participate in the *plan*, *provided you* are enrolled. Eligible *dependent(s)* include:

- *Your dependent* children who are under the age of 26. For this purpose, your dependent children include *your* natural children; stepchildren; children who, before reaching age 18 were adopted by *you* or were legally placed in *your* home for adoption; children for whom *you* have assumed permanent legal guardianship or who is your eligible foster child; or natural or adopted children of *your domestic partner*, if *you* enroll *your domestic partner*.
- *Your* lawful *spouse*, as defined by the state law of *your* primary residence.
- *Your domestic partner*, as defined by the Aurora Health Care *Domestic Partner* Benefits policy.

Dependent children remain eligible to participate in the *plan* until the end of the *pay period* in which they reach age 26. If your child is *disabled*, he or she may be able to remain covered for a longer period as described below.

You may also enroll (or continue the enrollment of) *your dependent* child who is older than age 26 if **all** of the following requirements are met:

-- the child became *disabled* prior to age 26;

-- the child has been continually *disabled* since that time;

-- the child is unmarried, the child resides with you for more than one-half of the year, and the child does not provide more than one-half of his/her own support; and

-- the child has been continuously covered under this health plan or the health plan of *your* prior employer(s) from the date of the *disability*, without a gap in coverage. The plan may require *you* to provide proof that all of the above requirements have been met in order to enroll or continue the enrollment of *your disabled dependent* child.

Your disabled dependent child will cease to be eligible to participate in the plan on the date that any one of the above requirements is no longer met.

Effective January 1, 2011, grandchildren are no longer eligible to be covered by the plan.

You may not participate in this *plan* as both an *employee* and a *dependent*, and *your dependent*(s) may not participate in this *plan* as a *dependent* of more than one *employee*.

If *your employer* determines that *your* separated or divorced *spouse* or any state child support or Medicaid agency has obtained a legal qualified medical

child support order (QMCSO) through a court order or an administrative process established under state law, and *your* current plan offers *dependent* coverage, *you* will be required to provide coverage for any child(ren) named in the QMCSO, as long as the child is otherwise eligible (excluding the residence and support requirements for *disabled dependent* children). If a QMCSO requires that *you* provide medical coverage for *your* child(ren) and *you* do not enroll the child(ren), *your employer* must enroll *you* (if *you* are not already enrolled) and the child(ren) upon application from *your* separated or divorced *spouse*, the state child support agency or Medicaid agency and withhold from *your* pay *your* share of the cost of such coverage. *You* may not terminate coverage for *yourself* and the child(ren) unless *you* submit written evidence to *your employer* that the child support order is no longer in effect. The *plan* may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). You may obtain a copy of the *plan's* QMCSO procedures without charge through *your* local human resources department.

Who Pays for Your Benefits

Although Aurora Health Care may pay part of the cost of this *plan*, *you* share in the cost of *your* medical care coverage. The amount of *your* contribution is based on the coverage *you* select and the number of *dependent*(s) *you* cover under the *plan*. *You* have a choice of four coverage levels:

- Single - *yourself* only;
- Employee + *Spouse* - *you* and a *spouse* or same gender *domestic partner;*
- Employee + Child(ren) – *you* and one or more *dependent* children; or
- Family - *you* and a *spouse or same gender domestic partner* and one or more *dependent* children.

With four coverage levels, *you* can cover and pay for only those *dependent*(s) who actually need coverage. It is *your* responsibility to choose the coverage level appropriate for *you*.

Your choice of AACN Option 1 or Option 2 should be based on the amount of *your* contribution toward the cost of coverage and the *plan* benefits provided under that option. AACN Option 1 is a comprehensive plan, with higher premiums than AACN Option 2. AACN Option 2 offers lesser benefits while *you* pay a lower contribution. Option 2 meets Internal Revenue Service guidelines as a *High Deductible Health Plan* (HDHP). Participating in Option 2 can, under certain circumstances, result in a significant *employee* financial obligation. If *you* enroll in Option 2 *you* may also be eligible to enroll in a Health Savings Account.

Your contributions, made through payroll deductions, are made on a pre-tax basis. The dollars come out of *your* paycheck before federal, state and Social Security taxes are deducted. In other words, *your* taxable income is reduced by the amount of *your plan* contribution. Less taxable income means *you* pay lower taxes. The taxes *you* save make this a more inexpensive way to purchase coverage. However, *you* may not be able to make pre-tax payroll deductions for individuals who do not qualify as *your* tax dependents under Federal or state law, and the value of the employer-provided coverage for such individuals may be treated as compensation, reportable on *your* Form W-2.

Aurora Contribution to AuroraFlex

If your family income is below established guidelines and you enroll in AACN Option 2, you may be eligible to receive an Aurora contribution to your AuroraFlex Health Care Account, which funds an account to help *you* pay for eligible medical expenses such as the *deductible*, *co-insurance* and *prescription drug* costs. If *you* enroll in AACN Option 2 and wish to apply for an Aurora contribution to the AuroraFlex Health Care Account, you must complete the Confirmation of Family Income Form found on the Employee Connection. Income eligibility is determined at time of enrollment. This form must be returned within 30 days of your date of hire, within 60 days of a qualifying event, or within the annual enrollment deadline for the following year.

Domestic Partners

There are important tax factors to be aware of when an *employee* covers *a domestic partner*. In general, the value of *domestic partner* benefits is considered taxable income by the IRS unless the *domestic partner* and/or any *dependents* of the *domestic partner* are the employee's tax *dependent* for federal income tax purposes. *You* should contact *your* tax advisor if *you* require additional information on the tax implications of benefits for *domestic partners*.

Changes to Your Contributions

The amount of *your* contribution to the *plan* may change each *year*. *You* will be informed of the costs during the annual enrollment period each *year*. In addition, the amount of *your* contribution may change if *you* make coverage changes mid-year as described below.

When Coverage Begins

If *you* are a benefit-eligible *employee* and *you* are hired after the first day of the month, *your* coverage begins on the first day of the month following *your* date of hire when the enrollment requirements are met. If *you* are hired on the first of the month and have met enrollment requirements, *your* coverage will be effective on the first of the month in which *you* were hired. If *you* have a mid-year enrollment change, please review the effective dates of these changes in Appendix B. Coverage for *your dependent*(s) begins on the latest of when *your* coverage begins, or the first day a *dependent* is legally acquired or satisfies the eligibility requirements if properly enrolled in the *plan*.

If *you* are a *retiree*, please review Retiree Coverage (see table of contents).

Enrollment Guidelines

You must enroll by logging on to iConnect and then going to the Employee Connection.

Initial Enrollment – Newly Hired

You must enroll by logging on to iConnect and then go to the Employee Connection within 30 days of *your* first becoming eligible for coverage. If *you* also desire *dependent* coverage, *you* must enroll *your dependent*(s) at this time. If *you* do not have any eligible *dependent*(s) at the time of initial enrollment, but acquire eligible *dependent*(s) at a later date, *you* must enroll the *dependent*(s) within 60 days of the date *you* acquire them. *You* will be required to provide *your employer* with dependent verification documentation and a Social Security number for each covered *dependent*.

If *you* or *your dependent*(s) are not enrolled within 30 days of the date *you*

first become eligible to participate in this *plan*, *you* may enroll in the *plan* only if *you* have a qualifying mid-year enrollment event as described more fully in the next section of this booklet. *You* may also enroll in the *plan* during the annual enrollment period.

Mid-Year Enrollment

Your (and *your dependent's)* enrollment cannot be changed for the duration of the *Plan Year* unless *you* or *your dependent* qualify for one of the Mid-Year Enrollment Events described below as Special Enrollment, Change in Status, Change in Cost or Coverage, or Other Legal Events. *You* may enroll (or disenroll) *yourself* and *your dependent*(s) in the *plan* provided *you* complete the enrollment process by logging on to iConnect and then going to the Employee Connection within 60 days of the change (i.e., within 60 days for a new *dependent*).

You must disenroll any *dependent who fails to qualify as a dependent*, such as due to divorce. The *plan* will automatically disenroll any *dependent* child at the end of the pay period in which they turn age 26. If benefits are paid after a *dependent* ceases to be eligible, the *plan* may recover from *you* or the *dependent* the amount of benefits that were paid after the *dependent* ceased to be eligible. Accordingly, even though the Plan provides a 60-day period for *you* to disenroll ineligible *dependents*, you should disenroll *your* ineligible *dependents* promptly.

You will be charged for the coverage depending on the date of enrollment or cancellation.

Your portion of the premium will be deducted from every paycheck . A *dependent* added during a pay period will generate a premium for that *dependent* for that pay period. Benefits for terminated *dependent(s)* will end at the end of the pay period during which the individual is no longer a *dependent*.

Special Enrollment

- Loss of Other Coverage. If *you* declined coverage under this *plan* for *yourself* and/or *your dependent*s when you were initially eligible or during any annual enrollment period because *you* or your *dependents* were covered by other medical plan coverage at that time, *you* are eligible to enroll *yourself* and/or *your dependents* in this *plan* within 60 days of:

  --the date coverage under the previous medical plan ends as a result of loss of eligibility for coverage (for other than failure to pay premiums or for cause), or

  -- the date coverage under the previous medical plan ends as a result of exhaustion of COBRA, or

  -- the date of termination of employer contributions towards the cost of the other coverage.

  If *you* declined coverage because *you* had other medical coverage, then *you* may enroll *yourself* and any of *your dependents*. If *you* declined coverage on behalf of a *dependent* because the *dependent* had other coverage, then *you* may only enroll the *dependent* who lost coverage (as well as *yourself*, if *you* are not already enrolled).

  If *you* are already enrolled in the Plan, *you* can also elect to switch coverage options from AACN Option 1 to AACN Option 2, or vice versa, at the time of the special enrollment of

your *dependents*. However, if *you* switch options, *your* deductible and other out-of-pocket costs will not carry over from one option to the other.

You complete the enrollment process by logging on to iConnect and then going to the Employee Connection within 60 days of the change.

If *you* enroll and provide dependent verification document timely, coverage for the newly enrolled individual(s) will become effective the day after the prior coverage is lost.

- Acquisition of New *Dependent*. If *you* have a new *dependent* as a result of marriage, *domestic partnership*, birth, adoption, or placement for adoption, *you* may enroll *yourself* and *your dependents*, provided *you* complete the enrollment process by logging on to iConnect and then going to the Employee Connection within 60 days of the change.

  If *you* are already enrolled in the Plan, *you* can also elect to switch coverage options from AACN Option 1 to AACN Option 2, or vice versa, at the time of the special enrollment of *your* eligible *dependents*. However, if *you* switch options, *your* deductible and other out-of-pocket costs will not carry over from one option to the other.

  If *you* enroll and provide dependent verification documentation timely, coverage for the newly enrolled individual(s) will become effective as of the date *you* acquired the *dependent*.

Change in Status

A qualifying change in status includes any of the following events that cause an individual to become eligible for or cease to be eligible for coverage under the *plan* or the plan of the *dependent's* employer:

- Change in legal marital status. Events that change an *employee*'s marital status, including: marriage, divorce, legal separation or annulment.
- Change in *domestic partnership* status. The *employee's* creation or termination of a *domestic partnership*.
- Change in number of *dependents*. Events that change an *employee's* number of *dependents*, including: birth, death, adoption and placement for adoption.
- Change in *dependent* child eligibility. Events which cause an *employee's dependent* child to satisfy or cease to satisfy the requirements for coverage due to reaching a specific age, ceasing to be *disabled* or any similar circumstance provided in the *plan*.
- Change in residence. A change in the residence of the *employee's dependent* that affects eligibility for coverage under the *dependent's* employer plan.
- Change in employment status. Events that change the employment status of an *employee* or the *employee's dependent*:
  - Termination or commencement of employment.
  - Beginning or returning from an unpaid leave.
  - Change in worksite of the *employee's dependent* that affects eligibility for coverage

under the *dependent's* employer plan.

- Change in employment status (e.g., non-benefit eligible to benefit eligible) so that an individual becomes (or ceases to be) eligible for a plan.

The change in *your* (or *your dependent's)* coverage election must be consistent with the change in status. For example: A marriage would allow *you* to add *your spouse* and his or her legal dependents and change from a single *plan* to a family *plan*.

Change in Cost or Coverage

- If Aurora Health Care determines that a significant change in the cost or coverage of the *plan* has occurred within IRS guidelines, *you* will be notified of *your* election options.
- If the group health plan of *your dependent* operates on a different plan *year* with a different open enrollment period, *you* may make election changes under this *plan* that correspond to the election made by *your dependent* under *your dependent*'s employer's plan.

Legal Events

The following events may also allow *you* to make a mid-year change in *your* election of coverage under the *plan:*

- A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order, which requires health coverage for *your* child.
- Gain or loss of coverage by *you* or *your dependent* under *Medicare* or Medicaid.

Open Enrollment

You have an opportunity to change *your* election during the open enrollment period that occurs at the end of each plan *year*. This open enrollment period is approximately 21 days in duration and generally occurs in October/ November or as otherwise designated by Aurora Health Care. Coverage changes made during the open enrollment period will be effective on the following January 1st.

Pre-Existing Conditions

A pre-existing condition is any *illness* or *injury* for which medical advice, diagnosis, care or treatment (including prescribed drugs or medicines) has been recommended by or received from a licensed pharmacist, *physician* or health care *practitioner* within six months prior to the *enrollment date* of coverage. This pre-existing condition limitation does not apply to individuals under the age of 19.

If *you* or *your dependent*(s) age 19 or older have a pre-existing condition, any related expenses will not be paid under this *plan* if they are incurred before 12 consecutive months of participation in this *plan*. The pre-existing condition exclusion will not apply to pregnancy The pre-existing condition exclusion will not apply to *you* and *your dependent*s age 19 or older if *you* enroll during *your* initial enrollment eligibility period (i.e. as a new hire). Genetic information is not an indicator of a pre-existing condition if there is not a diagnosis of a condition related to the genetic information.

If *you* and any *dependent*(s) age 19 or older *you* wish to enroll were covered by another medical plan for at least twelve months without a lapse in coverage of 63 or more consecutive days (not including waiting periods) prior to being covered under this *plan*, *you* or *your dependent(s)* will not be subject to the

pre-existing conditions clause. If *you* or *your dependent(s) age 19 or older* do not have proof of such prior medical coverage as described below, *you or your dependent(s)* will be subject to the *plan*'s 12-month pre-existing conditions clause.

The pre-existing exclusion period may be reduced by the number of days *you* were covered under a prior medical plan. *You* or *your dependent(s)* have the right to demonstrate coverage under a prior medical plan. To do this, *you* or *your dependent(s)* may request proof (i.e., a certificate of creditable coverage) from a prior medical plan or insurer, and provide it to *the plan administrator*. If necessary, the *plan administrator* will assist *you* or *your dependent(s)* in obtaining proof of coverage. If, after due efforts, it becomes apparent that proof is unavailable, the *plan* will take into account relevant facts and circumstances to determine whether *you* or *your dependent(s)* have qualifying coverage.

Once the amount of *your* (or *your dependent's)* prior qualifying coverage has been determined, *you* or *your dependent(s)* will receive a notice stating the length of *your pre-existing condition* exclusion period under this *plan*, if any. If *you* or *your dependent(s)* wish to appeal the determination of the *pre-existing condition* exclusion period, *you* or *your dependents)* can do so by following the procedures for claims appeals that appear elsewhere in this booklet.

Any time accumulated toward satisfaction of the pre-existing condition limitation under any other previous Aurora Health Care plan will be counted toward the satisfaction of the pre-existing condition limitation of this *plan*.

When Coverage Ends

If *you* are an *active employee*, *your* coverage ends the earliest of:

- the end of the pay period in which *you* cease to be eligible, such as because *your* employment with Aurora Health Care ends or because *you* transfer to an ineligible position, provided *you* have paid the required premiums through the end of the pay period; otherwise, coverage ends at the end of the pay period in which *you* cease to be eligible,
- the end of the pay period for which *your* last timely required contribution was paid, or
- the date the *plan* terminates.

You must remain enrolled in order to maintain benefit eligibility for *your* dependents.

Coverage for *your dependent*(s) ends the earliest of:

- the date on which *your* coverage ends;
- the last day of the pay period in which *your* dependent child ceases to be eligible (for reasons other than divorce or termination of *domestic partnership*), provided *you* have paid the required premiums through the end of the pay period; otherwise, coverage ends at the end of the pay period in which *your dependent* ceases to be eligible;
- the date of divorce or termination of *domestic partnership* with respect to those *dependents* who cease to be eligible as a result of such event; or
- the date *dependent* coverage is no longer offered by the *plan*.

If *you* die, coverage for *your* dependents ends the end of the month following the month of death, provided *your*

dependents timely pay the required premiums for such coverage.

The *plan administrator* can also terminate coverage for *you* and *your dependent*(s) at any time if *you* or any covered *dependent*(s) allow any unauthorized person to use *your* identification card to receive medical coverage under this *plan*.

Payment of PTO and/or other benefit accruals after *your* last day of employment does not count toward *your* continuation of employment for medical plan eligibility purposes.

Aurora Health Care intends the *plan* to be continued indefinitely. But since future conditions affecting *your employer* cannot be anticipated or foreseen, Aurora Health Care reserves the right to *amend*, modify or terminate the *plan* in any manner or change the amount of employee contributions for coverage, at any time, which may result in the termination or modification of *your* coverage. Expenses incurred prior to the *plan* amendment or termination will be paid as provided under the terms of the *plan* prior to the effective date of its amendment or its termination.

When *you* and/or *your dependents'* coverage terminates, the *plan* will provide *you* with a certificate of creditable coverage. *You* may also receive this certificate upon request, if made within 24 months following *your* termination of coverage. *You* should keep a copy of this certificate in case *you* need it to prove *you* had prior coverage when *you* enroll in a new medical plan that has a pre-existing condition exclusion.

Reinstatement of Coverage

Following Active Military Duty

Whether or not *you* elect continuation coverage under the Uniformed Services Employment and Re-employment Rights Act ("USERRA") during military service, coverage will be reinstated upon *your* request, on the first day *you* return to *active employment*, if *you* are released under honorable conditions and *you* return to employment:

- On the first full business day following completion of *your* military service for a leave of 30 days or less;
- Within 14 days of completing *your* military service for a leave of 31 to 180 days; or
- Within 90 days of completing *your* military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an *illness* or *injury* determined by the Veteran's Administration (VA) to be service-connected will be allowed).

If *you* are hospitalized for, or recovering from, an *illness* or *injury* when *your* military leave expires, *you* have two years to apply for reemployment. If *you* provide written notice of intent not to return to work after military leave, *you* are not entitled to reemployment benefits. *You* must request reinstatement in the *plan* within 60 days of returning to *active employment*.

When coverage under this *plan* is reinstated, all provisions and limitations of this *plan* will apply to the extent that they would have applied if *you* had not taken military leave and *your* coverage had been continuous under this *plan*. The eligibility-waiting period will be waived and any pre-existing condition

limitation will be credited as if *you* had been continuously covered under this *plan* from *your* original effective date. (This waiver of limitations does not provide coverage for any *illness* or *injury* caused or aggravated by *your* military service, as determined by the VA).

Termination of Coverage During FMLA Leave

If *you* do not elect to continue health coverage or if coverage is terminated for failure to make premium payments while *you* are on an approved family or medical leave of absence (as defined in the Family and Medical Leave Act, or FMLA), coverage for *you* and *your* eligible *dependent*(s) will be reinstated upon *your* request, on the date *you* return to *active employment* if *you* and *your dependent*(s) are otherwise eligible under the *plan*. *You* must return to *active employment* within the statutory FMLA period and must request reinstatement within 60 days of returning to *active employment*. The pre-existing condition limitation and any waiting periods will not apply. However, all accumulated annual out-of-pocket and benefit maximums will apply.

If *you* do not return to work after *your* FMLA leave, *you* and *your dependent* may continue coverage under COBRA continuation coverage as described later in the booklet. Coverage continued during an FMLA leave will not be counted toward the maximum COBRA continuation period.

Termination of Coverage During Non-FMLA Leave

If *you* do not elect to continue health coverage or if coverage is terminated for failure to make premium payments while *you* are on an approved non-FMLA leave of absence, coverage for *you* and *your* eligible *dependent*(s) will be reinstated upon *your* request on the first day of the month following the leave if *you* and *your dependent*(s) meet the eligibility requirements and *you* return to *active employment* immediately following the end of the leave. If *you* return on the 1st of the month, coverage will be reinstated that day. *You* must request reinstatement within 60 days of returning to *active employment*. Any time accumulated toward satisfaction of the pre-existing condition limitation and all accumulated annual out-of-pocket and benefit maximums will apply.

Extension of Coverage

In addition to the rights described in this section, *you* and/or *your dependent*s may also have rights to continue coverage under COBRA.

Approved Family or Medical Leave of Absence

If *you* qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act, or FMLA), eligibility may continue for the duration of the leave if *you* pay any required contribution toward the cost of the coverage. *Your employer* has the responsibility to provide *you* with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by *your employer* will result in termination of coverage retroactively to the beginning of the pay period for which a contribution was due and remains unpaid. Subject to certain exceptions, if *you* fail to return to work after the leave of absence, *your employer* has the right to recover, from *you*, any contributions toward the cost of coverage made on *your* behalf during the leave, as outlined in the FMLA.

Approved Non-FMLA Leave of Absence

If *you* qualify for an approved non-FMLA leave of absence, eligibility may continue for the duration of the leave. For the period of time *your* leave is paid for *your* own personal *illness* or *injury*, *you* must pay the same amount *you* would pay if *you* were actively working. If *your* leave for *your* own personal *illness* or *injury* is unpaid or if the leave is for other than *your* own personal *illness* or *injury*, *you* must pay the full cost of coverage. Failure to make payment by the due date established by *your employer* will result in termination of coverage retroactively to the beginning of the period for which a contribution was due and remains unpaid.

Military Active Duty

If *you* or *your dependent* were covered under this *plan* immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to the lesser of 24 months or a period that ends the day after *you* fail to apply for or return to work as provided under USERRA, whichever is shortest, if *you* timely pay any required contributions toward the cost. Coverage continued during the military service will be counted toward the maximum COBRA continuation period. The 24-month period is measured from the last day of the month in which *you* leave for military service. If the leave is less than 30 days, the contribution rate will be the same as for *active employees*. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

Retiree Coverage

Who is Eligible

Aurora Health Care currently offers medical coverage to *retirees* who have coverage under this *plan* prior to retirement. *You* qualify as a *retiree* if *you* were a *covered person* in an Aurora Health Care sponsored retirement plan when *you* terminated *your* employment with Aurora:

- On or after *your* 55th birthday; and
- With 10 or more years of vesting service in an Aurora Health Care sponsored retirement plan;
  and
  - *You* began receiving monthly pension payments from the Aurora Health Care Pension Plan within 30 days of *your* termination from *active employment* with Aurora;
    or
  - If *you* are eligible, and *you* elect an immediate payment from an Aurora Health Care sponsored retirement plan within 30 days of *your* termination from *active employment* with Aurora Health Care.

If *you* terminate *your* employment on or after age 55 with 10 or more years of vesting service under an Aurora Health Care sponsored retirement plan and elect to defer *your* pension payment until a later date, *you* do not qualify for *retiree* medical coverage. If *you* did not have medical coverage as an *active employee* prior to retirement *you* will not be covered by this *plan* after retirement.

Eligible *Dependent*s

Your covered *dependents* may also continue to participate in the *plan's retiree* coverage if *you* enroll as a *retiree*.

You may only enroll *your domestic partner* in the *plan* if *you* have submitted a valid Affidavit of *Domestic Partnership* prior to *your* retirement date, but *you* may otherwise enroll any other of *your dependent(s)* on or subsequent to *your* retirement date, as set forth below.

Subject to the restriction described immediately above, if *you* have a new *dependent* as a result of marriage, *domestic partnership*, birth, adoption, or placement for adoption, *you* may enroll *your dependents*, provided *you* complete the enrollment process by returning a completed enrollment form to the benefits department within 60 days of the change.

You can also elect to switch coverage options from AACN Option 1 to AACN Option 2, or vice versa, at the time of the special enrollment of *your dependents*. However, if *you* switch options, *your* deductible and other out-of-pocket costs will not carry over from one option to the other.

If *you* enroll and provide dependent verification documentation timely, coverage for the newly enrolled individual(s) will become effective as of the date *you* acquired the *dependent*.

Retiree Medical Coverage and COBRA

If *you* elect *retiree* medical coverage, COBRA medical coverage will not apply to *you*, but may in some instances apply to *your dependents* if there is another qualifying event as defined under COBRA (please see the section entitled "Optional Continuation of Coverage" later in this booklet). *You* should carefully consider *Retiree* medical

coverage before *you* elect *COBRA* medical coverage. If *you* elect COBRA coverage, *you* **may not** elect *retiree* medical coverage at a later date.

Who Pays for Your Benefits

You will be required to pay the full cost of coverage after *you* retire. Aurora Health Care does not make contributions toward the cost of *retiree* medical coverage.

Integration with Medicare

Medical coverage through Aurora Health Care will be integrated with Parts A and B of *Medicare*. *You* and *your* covered *dependents*, if any, must apply for Parts A and B of *Medicare* on a timely basis so *you* do not suffer a reduction in *your* medical coverage. The *plan* is secondary for *retirees* eligible for *Medicare*, whether or not they have applied for it. Once you have obtained *Medicare* coverage Parts A and B *you* should notify the Employee Benefits Department.

Prescription Drug **Coverage**

The *retiree* coverage does not provide *prescription drug* benefits for *Medicare* eligible retired employees and their covered *dependent*s who are age 65 or older. *Prescription drug* benefits are available under a program known as *Medicare* Part D. For details on *Medicare* coverage, call *Medicare* at 1-800-633-4227 or visit www.*medicare*.gov online.

When Coverage Ends

If *you* are a *retiree*, *your* coverage ends the earliest of:

- the end of the month for which the last timely required contribution was paid;
- the date of *your* death;
- the date retiree coverage is no longer offered by the *plan*; or
- the date the *plan* terminates.

You must remain enrolled in order to maintain benefit eligibility for your *dependents*.

Coverage for *your dependent(s)* ends the earliest of:

- the date on which *your* coverage ends (unless *you* die, see below);
- the date of *your dependent's* death;
- the last day of the month in which *your dependent* child ceases to be eligible (for reasons other than divorce or termination of *domestic partnership*), provided *you* have paid the required premiums through the end of the month;
- the date of divorce or termination of *domestic partnership* with respect to those *dependents* who cease to be eligible as a result of such event; or
- the date *dependent* coverage is no longer offered by the *plan*.

If you die, coverage for *your dependent(s)* ends the earliest of:

- the end of the month for which the last timely required contribution was paid for such *dependent(s)*;
- the date of *your dependent's* death;
- the last day of the month in which *your dependent* child ceases to be eligible, provided such *dependent* child has paid the required premiums through the end of the month;
- the date *dependent* coverage is no longer offered by the *plan*; or
- the date the *plan* terminates.

How the *Plan* Works

When *you* or *your dependent* receives medical care, *you* can choose to go in or out of the Aurora Accountable Care Network (AACN). When *you* use a network provider, the *plan* will pay a higher percentage of *your* expense.

What is an In-Network Provider?

An *in-network provider* is a *physician*, *hospital*, or other *health care provider* contracted by AACN in an effort to reduce the effect of rising medical care costs while providing *you* with quality care. An AACN Provider directory of participating providers is available in *your* local human resources department or through iConnect.

About Your *In-Network Provider*

AACN has carefully selected the participating *physicians*, *hospitals*, pharmacies and other *health care providers* in the AACN network. The qualifications of each *health care provider* have been reviewed so *you* and *your dependent*(s) will be provided quality care at a *negotiated fee* rather than the *usual and customary fee* commonly charged by providers in the geographic area where *you* or your dependent receive the medical care. Each and every time *you* or *your dependent* require medical services, *you* or *your dependent* decide whether to use a provider in the AACN network or one not in the AACN network.

If You Use a Provider in the AACN Network:

- The provider *you* or *your dependent* use must be listed in the AACN provider directory;
- *You* and *your dependent*(s) must satisfy the annual *plan deductible*(s) before this *plan* will consider benefit payment;
- *You* and *your dependent*(s) receive benefits for preventive services (refer to the “Summary of Benefits” and “What the *Plan* Covers” sections of this book for specifics); and
- *Your* provider files claims directly with UMR (See the section of this booklet entitled "How to File Claims" for contact information and filing procedures.)

If You Use a Provider Not in the AACN Network:

- *You* and *your dependent*(s) may choose to receive care from any *hospital* or *physician*;
- *You* and *your dependent*(s) will be responsible for any charge for a service rendered by an *out-of-network provider* that is more than the *usual and customary charge* for that service. Any charge above the *usual and customary charge* for a service is not eligible for consideration by this *plan*;
- *You* and *your dependent*(s) must satisfy annual *plan deductible*(s) before this *plan* will consider benefit payment;

- *You* and *your dependent*(s) are responsible for any eligible charge not paid by this *plan*; and
- *You* and *your dependent*(s) are subject to greater annual *plan* out-of-pocket limit(s) and greater co-insurance percentages.

The final choice of *health care providers* is *your*s. However, remember if *you* receive medical care from an AACN network provider, *your* out-of-pocket expenses will be less. If *you* and *your dependent* receive medical care from a provider not in the AACN network, *your* out-of-pocket expenses will be more. Charges for services rendered by an *out-of-network provider* require *you* to pay a higher *deductible* and higher *co-insurance*.

Referrals/Primary Care Physicians

You or *your dependent* are not required to receive a referral from *your* (or *your dependent's)* primary care *physician* to see a specialist. However, *you* or *your dependent* may want to ask *your* (or *your dependent's)* primary care *physician* to coordinate *your* care and to suggest specialists within the network.

You and *your dependent* do not need to choose a primary care *physician* when enrolling in the *plan*.

Deductible

A *deductible* is what *you* pay each calendar year for eligible medical services, such as physician office visits, x-rays and lab tests, before the plan will pay for any eligible expenses. If *you* use both In-Network and Out-of-Network providers, two separate deductibles apply. The deductible does not apply to preventive services obtained in-network.

Aurora Accountable Care Network (AACN) Option 1

The *deductible* applies to all covered benefits under the *plan* except preventive care and *outpatient prescription drugs*. The individual *deductible* applies to each *covered person*. The *plan* begins to share costs after this *deductible* is met. The employee + child(ren)/ employee + *spouse*/family *deductible* applies to all covered family members. Once at least two individuals meet the employee + child(ren)/ employee + *spouse*/family *deductible* amount, no further *deductibles* will apply to any other members of the family during the same calendar *year*. The annual individual and employee + child(ren)/ employee + *spouse*/family *deductible* amounts are shown in the "Summary of Benefits" at the beginning of this booklet.

Aurora Accountable Care Network (AACN) Option 2

The *deductible* applies to all covered benefits under the *plan* except preventive care. The *deductible* does apply to *prescription drugs* under Option 2, meaning that you will be responsible for the entire cost of a prescription. The single coverage *deductible* applies only if you have just yourself covered under the medical plan. The *plan* begins to share costs after this *deductible* is met. If you have employee + child(ren), employee + *spouse* or family coverage, the *deductible* must be met by the first claims incurred during the *year*, regardless of whom they are for. One participant could be responsible for the full *deductible* amount if the claims for the *year* meet the *deductible*. Once the family *deductible* amount has been met, no further *deductibles* will apply to any other members of the family during the same calendar *year*. The annual

deductible amounts are shown in the "Summary of Benefits" at the beginning of this booklet.

Co-insurance

Co-insurance is the portion of covered expenses paid by *you* and by the *plan*. The *co-insurance* applies only to covered medical expenses that do not exceed the *usual and customary charge* or the *negotiated fee* for a provider in the AACN .

- *You* are responsible for all non-covered medical expenses and any amounts that exceed the *usual and customary fee* for covered medical expenses.
- When using a provider in the AACN for a covered medical service, *you* will be required to pay *co-insurance* only on the *negotiated fee* charged by the *in-network provider*.
- Remember, *you* must first pay *your* annual individual and/or family *deductible* before the *plan* shares with *you* the cost for covered medical services through *co-insurance*.
- The *co-insurance* amounts are shown in the "Summary of Benefits" sections at the beginning of this booklet.

Benefit Maximums

Some categories of *plan* payments for each *covered person* are limited to certain maximum benefit amounts or maximum limits on number of days of coverage or similar limits. A benefit maximum also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in the *plan* in reference to benefit maximums, it refers to the period of time *you* or *your* eligible *dependent*(s) participate in the *plan* or another medical plan sponsored by Aurora Health Care.

The benefit maximums applicable to the *plan* are shown in the "Summary of Benefits" at the beginning of this booklet.

In-Network Vs. Out-of-Network Costs Examples

Option 1 Vs. Option 2 Costs Examples

Example 1: $1,000 In-Network Medical Expense

Suppose *you* receive medical care from an *in-network provider*. *Your* entire bill adds up to $1,000 in covered expenses. Here is how costs may compare:

	AACN Option 1		**AACN Option 2**	
	In-Network ($500 Single Coverage *Deductible* Not Met)	In-Network ($500 Single Coverage *Deductible* Met)	In-Network ($1,800 Single Coverage *Deductible* Not Met)	In-Network ($1,800 Single Coverage *Deductible* Met)
Total Submitted Charges	$1,000	$1,000	$1,000	$1,000
Less *In-Network Provider* Discount	$100	$100	$100	$100
Total Eligible Charges	$900	$900	$900	$900
Amount Applied Toward Annual *Deductible*	$500	Satisfied	$900	Satisfied
Co-insurance (Your %)	$60 (15%)	$135 (15%)	$0	$225 (25%)
Total *You* Pay	$560	$135	$900	$225
Plan Pays	$340	$765	$0	$675

Note:

You must first pay a *deductible* toward in-network covered charges before the *plan* pays anything.

Example 2: $1,000 – Out-of-Network Medical Expense

Suppose *you* receive medical care from an *out-of-network provider*. *Your* entire bill adds up to $1,000 in covered expenses. Here is how costs may compare:

	AACN Option 1		**AACN Option 2**	
	Out-of-Network ($1,000 Single Coverage *Deductible* Not Met)	Out-of-Network ($1,000 Single Coverage *Deductible* Met)	Out-of-Network ($3,600 Single Coverage *Deductible* Not Met)	Out-of-Network ($3,600 Single Coverage *Deductible* Met)
Total Submitted Charges	$1,000	$1,000	$1,000	$1,000
Usual and Customary Fees	$950	$950	$950	$950
Total Eligible Charges	$950	$950	$950	$950
Amount Applied Toward Annual *Deductible*	$950	Satisfied	$950	Satisfied
Co-insurance (Your %)	$0	$427.50 (45%)	$0 (N/A)	$427.50 (45%)
Total *You* Pay	$1,000	$477.50	$1,000	$477.50
Plan Pays	$0	$522.50	$0	$522.50

Notes:

You must first pay a *deductible* toward out-of-network covered charges before the *plan* pays anything.

You must pay any costs above the *Usual and Customary Fees*. These costs are included in the Total You Pay.

Example 3: $15,000 In-Network Medical Expense – Annual Out-of-Pocket Maximum

Suppose *you* require medical care that requires several days of *inpatient* treatment from an *in-network provider* and *your* entire bill would add up to $15,000 in covered expenses. Here is how costs may compare:

	AACN Option 1		**AACN Option 2**	
	In-Network ($2,000 Single Coverage Annual Out-of-Pocket Max met)	In-Network ($2,000 Single Coverage Annual Out-of-Pocket Max Not met)	In-Network ($4,000 Single Coverage Annual Out-of-Pocket Max met)	In-Network ($4,000 Single Coverage Annual Out-of-Pocket Max Not met)
Total Submitted Charges	$15,000	$15,000	$15,000	$15,000
Less *In-Network Provider* Discount	$2,000	$2,000	$2,000	$2,000
Total Eligible Charges	$13,000	$13,000	$13,000	$13,000
Amount Applied Toward Annual *Deductible*	Satisfied	$500	Satisfied	$1,800
Co-insurance (Your %)	$0	$1,500 (15%)	$0	$2,200 (25%)*
Total *You* pay	$0	$2,000	$0	$4,000
Plan Pays	$13,000	$11,000	$13,000	$9,000

Notes:

You must first pay a *deductible* toward *in-network* covered charges before the *plan* pays anything.

*Annual Out-of-Pocket Maximum reached, so *co-insurance* is capped.

Example 4: Outpatient Prescription Drug Claims

Suppose *you* require *prescription drugs*. *You* purchase a generic *prescription drug* and a brand name drug. The total cost of a 30-day supply of the generic drug is $100; the total cost of a 30-day supply of the brand name drug is $250. *Prescription drug* costs are not applied toward *your deductible* and out-of pocket maximums in Option 1. There is a separate out-pocket maximum for AACN Option 1 for in-network prescription drugs of $2,000. After this maximum is met, then prescription drugs are paid at 100%. However, *prescription drug* costs are applied to *your deductible* and out-of-pocket maximum for Option 2. Here is how *in-network provider* costs may compare.

	AACN Option 1	**AACN Option 2**	
	In-Network (*Prescription Drugs* Do Not Apply Toward *Deductible*)	*In-Network* ($1,800 Single Coverage *Deductible* Not Met)	*In-Network* ($1,800 Single Coverage *Deductible* met)
Total Submitted Charges	$350	$350	$350
Co-insurance for Generic Drug	$7 (Generic co-pay)	$100 (Full cost)	$7 (Generic co-pay)
Co-insurance for Brand Name Drug on preferred list (Your %)	$50 (25%)*	$250 (Full cost)	$50 (25%)*
Amount Applied Toward Annual *Deductible*	N/A	$350	Satisfied
Co-insurance	$57	0	$57
Total *You* Pay	$57	$350	$57
Plan Pays	$293	$0	$293

*$50.00 maximum co-insurance per prescription for brand name drugs on the preferred drug list.

Example 5: Medical Claims for Several Family Members

You and *your* family members may require medical care. Suppose *you* require in-*network services totaling $2,000, then on a later day in the same plan year your spouse* requires *in-network* services totaling $7,000. Here is how *in-network* costs may compare when multiple family members are patients.

	AACN Option 1		**AACN Option 2**	
	In-Network ($1,000 Employee + *Spouse* / Family *Deductible* Not Met)	In-Network ($1,000 Employee + *Spouse* / Family *Deductible* Met)	In-Network ($3,600 Employee + *Spouse* / Family *Deductible* Not Met)	In-Network ($3,600 Employee + *Spouse* / Family *Deductible* Met)
Your Claim Total Eligible Charges	$2,000	$2,000	$2,000	$2,000
Your Claim Amount Applied Toward Annual *Deductible*	$500	Satisfied	$2,000	Satisfied
Co-insurance for Your Claim (Your %)	$225 (15%)	$300 (15%)	$0	$500 (25%)
Your Spouse's Claim Total Eligible Charges	$7,000	$7,000	$7,000	$7,000
Your Spouse's Claim Amount Applied Toward Annual *Deductible*	$500	Satisfied	$1,600	Satisfied
Co-insurance for *Your Spouse's Claim (Your %)*	$975 (15%)	$1,050 (15%)	$1,350 (25%)	$1,750
Total Amount Applied Toward Annual *Deductible*	$1,000 ($500 yours, $500 spouse's)	Satisfied	$3,600 ($2,000 *yours*, $1,600 *spouse*'s)	Satisfied
Co-insurance	$1,200 ($225 *yours*, $975 *spouse*'s)	$1,350	$1,350 ($0 *yours*, $1,350 *spouse*'s)	$2,250 ($500 *yours*, $1,750 *spouse*'s)
Total *You* Pay	$2,200	$1,350	$4,950	$2,250
Plan Pays	$6,800	$7,650	$4,050	$6,750

What the *Plan* Covers

When all of the provisions of the *plan* are satisfied, the *plan* will provide benefits as outlined in the "Summary of Benefits" for the medical services and supplies listed in this section. Benefits will be paid only if the expense is for a service, supply or treatment that is *medically necessary*, other than preventive services (unless otherwise noted). This list is intended to give *you* only a general description of expenses for medical services and supplies covered by the *plan*. If *you* or *your dependent* has any questions about whether a specific expense will be covered under the *plan*, please contact UMR (for medical claims) at 1-800-860-5217 or MedImpact (for prescription drugs) at 1-800-788-2949.

Diagnostic X-Ray and Laboratory Services

- Allergy testing.
- Amniocentesis.
- *Diagnostic charges* for laboratory services.
- *Diagnostic charges* for X-rays.
- *Infertility* charges for the diagnosis and treatment of *infertility*. *Lifetime* maximum of $2,500. Drugs used to treat *infertility* are not covered.
- Polysomnography; limited to two studies per *covered person* per *lifetime*, after a *physician* evaluation for the following conditions:
  - Documented sleep apnea; narcolepsy.
  - Home sleep pulse oximetry showing oxygen desaturation during sleep to under 90% in the face of normal daytime oximetry and in the presence of symptoms suggestive of a sleep disorder.
  - Snoring plus daytime somnolence, which is functionally significant; unexplained hypertension; functionally significant personality change; or *morbid obesity*. Snoring alone is not sufficient to justify the study.

    In addition, documentation must show that the patient was advised of the proposed treatment plan resulting from an abnormal study, and has agreed to proceed with the *plan*.
- Ultrasound.

Emergency Services and Supplies

- Ambulance service/*emergency*: ground or air transportation provided by a professional ambulance service to and from a *hospital* or *emergency* care facility equipped to treat a condition that can be classified as a *medical emergency*.
- Ambulance service/non-emergency: when *your* condition does not permit the use of other methods of transportation. Service must be used locally to or from a *hospital*, *skilled nursing facility*, or sanitarium; from *your* home; or from the scene of the *accident*. The ambulance service must meet state staffing requirements. This is a covered benefit ONLY if reviewed and approved as *medically necessary* by

the Aurora Medical Management Team.

- Stabilization or initiation of treatment in either a *hospital emergency* department or other *emergency* care facility.
- Treatment in a *hospital emergency* department or other *emergency* care facility for an accidental *injury*. Treatment must begin within 72 hours of the *accident* to be considered *emergency* care, unless a delay is *medically necessary*.

Equipment and Supplies

- Artificial limbs and eyes.
- Blood and/or plasma and the equipment for its administration.
- *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.
- Hearing aids and batteries; limited to $500 per *covered person* every three years.
- Insulin infusion pumps only if reviewed and approved as *medically necessary* by the Aurora Medical Management Team; limited to one per *covered person* per *year*.
- Jobst garments.
- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired.
- Orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet. Limit of one pair per *year*.
- Oxygen and rental of equipment required for its use.
- Prescription contact lenses or eyeglasses (initial pair only), including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery*.
- Sterile surgical supplies after *surgery*.

Equipment and Supplies Dispensed by a Pharmacy

- Aero chambers.
- Diabetic supplies. Benefits include glucose strips, lancets, syringes and needles, diagnostic strips, and glucometers.
- Insulin syringes.
- Peak flow meters.

Hospital Services and Supplies Inpatient

- *Hospital* confinement expenses for dental services if hospitalization is necessary to safeguard the life of the *covered person*.
- *Intensive care unit* and coronary care unit charges.
- Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.
- Room and board accommodations:
  - Private room and board (if *medically necessary)*. If a private room is the only accommodation available, the *plan* will cover an amount equal to the semi-private room rate in the providing facility. If accommodations are in a private-room-only facility, the *plan* will cover an amount equal to the private room rate of the facility.

- Accommodations for maternity stays. Maternity stays of up to 48 hours for a normal vaginal delivery and up to 96 hours for a cesarean section are covered just like any other *inpatient hospital* stay. The *plan* never requires a *health care provider* to obtain authorization for prescribing a length of stay up to these 48- and 96-hour periods. However, the *health care provider* may decide, in consultation with the mother, to discharge the mother or newborn earlier.
- Semi-private room and board accommodations. Semi-private accommodations are covered when ordered, provided, or arranged under the direction of a *physician*.
- Well-baby nursery, *physician* and initial exam expenses during the initial *hospital* confinement of a newborn. These services will be provided to the newborn prior to the mother's discharge from the *hospital*, only if the *employee* enrolls the newborn for *dependent* coverage within 60 days of the delivery date.
- Children's Hospital of Wisconsin is only considered in-network for members under age 18 unless an in-network exception is granted. Please refer to the Exception Review Process.

Outpatient

- *Hospital* services provided to a *covered person* on an *outpatient* basis.

- Children's Hospital of Wisconsin is only considered in-network for members under age 18 unless an in-network exception is granted. Please refer to the Exception Review Process.

Medical Services

- Bariatric surgery limited to one procedure per lifetime only if reviewed and approved as *medically necessary* by the Aurora Medical Management Team. Charges for non-surgical obesity treatment are covered provided treatment is *medically necessary* and the *covered person* is o*bese* (BMI 30+). Non-surgical obesity treatment is limited to: physician visits, diagnostic testing, consultations with dietitians and/or nutritionists. The following are not covered, regardless of *medical necessity*: weight control or reduction programs such as, but not limited to, food supplements, meal replacement programs (e.g. HMR, Jenny Craig and Weight Watchers), membership in health clubs or YMCAs, weight loss medications.

- Chemotherapy is covered. Also, high dose chemotherapy is a covered benefit if performed in conjunction with an approved bone marrow transplant or stem cell transplant (and only then in the case of a *covered person* who qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community).
- *Chiropractic services*; limited to $1,250 per *year*.
- Dental services received after an accidental *injury*. This includes replacement of teeth and any X-rays. Treatment must begin within 90 days of the accidental *injury*, unless a delay is *medically necessary* and pre-approved by the AACN Medical Management Team prior to providing the treatment.

- Diabetes self-management education program.
- Diabetic education provided in a physician's office, medical center, or specialized treatment facility as defined by the *plan* is covered at 100% if enrolled in AACN option 1. If enrolled in AACN option 2, diabetic education is subject to deductible and co-insurance.
- Diet counseling and education for *covered person* diagnosed with pre-diabetes, diabetes, congestive heart failure, hypercholesterolemia, eating disorders (anorexia nervosa, bulimia, and pica), celiac disease, Crohn's disease, hypertension, liver disease, malabsorption syndrome, metabolic syndrome, morbid obesity, multiple or severe food allergies, nutritional deficiencies, renal failure, and ulcerative colitis provided at an *in-network* physician's office, medical center, or specialized treatment facility as defined by the *plan.* To determine if your diagnosis qualifies under the Preventive Benefit schedule or General Medical Benefits, contact UMR.
- Family counseling.
- Foot treatment, including treatment of metabolic or peripheral-vascular disease. Benefits end once maximum medical recovery has been achieved and treatment is primarily for *maintenance care*.

  Routine foot care, including trimming of toenails, for *covered person* with diabetes or peripheral vascular disease. Limited to $150.00 per calendar *year* per *covered person*.
- Genetic counseling is only covered when received and approved as *medically necessary* by Aurora Medical Management.
- Hearing exam.
- Home health care provided by a *home health care agency*; limited to 40 visits per *covered person* per *year*.
- *Home hospice care* for a terminally ill *covered person*; limited to 80 visits per *covered person* per *year*.
- *Inpatient* Hospice at a licensed *hospice facility*.
- *Inpatient hospital physician* visits.
- Kidney disease. In the event a *covered person* becomes entitled to benefits under *Medicare* solely because of end stage renal disease, the *plan* will reimburse as the primary insurer for the period required by *Medicare*. After that period, the *plan* will reimburse as the secondary insurer even if the *covered person* does not apply for *Medicare* benefits.
- Maternity care, including customary *physician* medical services related to prenatal, labor, delivery, and postnatal care of the mother. Maternity benefits also are available for a daughter who is covered under the *plan* as an eligible *dependent*. Group medical plans and medical insurance issuers generally may not, under the federal Newborn and Mothers Health Protection Act, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *health care provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the *plan* may not, under federal law, require that a *health*

care provider obtain authorization from the *plan* for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- *Physician* office visits.
- Pregnancy termination, only when the life of the mother would be endangered if the fetus was carried to term.
- Radiation therapy is covered. Also, high dose radiotherapy is a covered benefit if performed in conjunction with an approved bone marrow transplant or stem cell transplant (and only then in the case of a *covered person* who qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community).
- *Second surgical opinions*.
- Self-inflicted *injury* or *illness* while sane or insane.
- Sleep disorder treatment, including *physician* evaluation.
- Sleep studies, limited to two for *lifetime*.

Mental Health Services and Substance Use Treatment

If *you* are seeking mental health services or substance use treatment, please call the Aurora Health Care Employee Assistance Program (EAP) at 1-800-236-3231. The EAP offers free, confidential consultation to help the *covered person* to assess and plan for their treatment needs and to access the best provider for needed care.

- Attention Deficit Disorder (ADD) treatment is covered only on an *outpatient* basis.
- Eating disorder treatment, including nutritional counseling for anorexia nervosa, bulimia, and pica.
- Treatment of substance use and/or mental/nervous disorder is covered with no limits applied to number of visits.
- *Outpatient* services by a provider within the AACN must be provided by an MD, psychologist, psychotherapist, certified alcohol and drug counselor (CADC) or a masters-prepared therapist.
- Residential treatment for a *covered person* must be provided at an *accredited residential treatment facility.* Please call the Aurora Behavioral Health Management team at 1-800-236-3231 to discuss your options.

Prescription Drugs

- Birth control pills and other Food and Drug Administration approved contraceptive devices or injectibles that requires a *physician's* prescription to purchase,Insulin (insulin syringes covered as a medical supply item).
- Therapeutic vitamins authorized by AACN where an over-the-counter alternative is not available.
- Prenatal vitamins when prescribed by a *physician* for a pregnant or lactating female.
- *Prescription drugs*, which are authorized by AACN, have a *physician's* written prescription, dispensed by a licensed pharmacist and are approved for human use by the Food and Drug Administration. At AACN pharmacies, generic drugs will be dispensed, unless *your physician* requests a brand-name drug.

- Retin-A for a *covered person* age 25 and under. Retin-A is a covered benefit for a *covered person* age 26 or older only if a *physician* establishes the drug as *medically necessary* for the drug's approved indication(s).

- A *covered person* is limited to a 30-day supply for most medications. However a *covered person* may receive up to three 30-day supplies at one time.

- Zyban and Chantix, the *prescription drugs* for smoking cessation, will be covered for a 30-day supply of the drug, with five refills for a 30-day supply. Total six-month supply per *year* per *covered person*.

- Smoking cessation products are a covered benefit if purchased at an Aurora retail pharmacy. Employees and their eligible *dependents* age 18 or older, pay 25% of the cost of the therapy, including the following over the counter nicotine replacement therapies:
  - transdermal patches
  - lozenges
  - resin gums

- Specialty prescription drugs are available in-network only, with a maximum co-insurance of $75 per prescription. Specialty prescriptions are limited to a 30-day supply.

- *Step Therapy* is required on three drug classes. *Step Therapy* requires a minimum of 30 days generic drug trial before the more costly brand-name drugs will be covered by the *plan*. The three drug classes are:
  1) Proton Pump Inhibitors;
  2) Cholesterol lowering agents, also known as statins; and,
  3) Angiotensin receptor blockers, also known as ARBs.

Should an employee choose not to complete the *Step Therapy* requirement, the employee will pay the full prescription price (the cost would not be covered by the *plan*).

Preventive Services

Preventive/routine services are medical services performed to prevent or detect disease in the absence of signs or symptoms. Benefits for preventive medical services are covered only if rendered by an *in-network provider*.

Wellness Screening Labs

- Urinalysis, blood glucose, Basic metabolic panel OR General Health Panel OR Comprehensive metabolic panel

- Wellness Exams
  - Well baby/child through age 6 (frequency as recommended by ACIP)
  - Well child age 7 & over – yearly
  - Wellness adult – yearly

- Abdominal Aortic Aneurysm Screening
  - One time abdominal aortic ultrasound for men age 65-75
- Alcohol Misuse Screening & Behavioral Counseling
  - Yearly - adults
- Anemia, Iron Deficiency Anemia Screening
  - One time screening with each pregnancy
- Bacteriura Screening
  - Pregnant women at 12 to 16 weeks gestation or at the first prenatal visit if later.
- Breast Cancer Screening – Genetic Counseling and Evaluation for BRCA Testing
  - One time for women whose family history is associated with an increased risk for breast cancer.
- Cervical Cancer Screening, Pap Smear
  - Once every three years for all women beginning age 21
- Chemoprevention of Breast Cancer Screening
  - One time for women at high risk for Breast Cancer and at low risk for adverse effects of chemoprevention
- Chlamydia Infection Screening
  - Yearly - all women
- Cholesterol Screen (Lipid Disorder Screening)
  - Yearly - All ages
- Colorectal Screening –Colonoscopy
  - One baseline colonoscopy in the year person turns age 50 and thereafter every 10 years
- Colorectal Screening-Fecal Occult Blood testing
  - Yearly age 50 and older
- Colorectal Screening-Sigmoidoscopy
  - One baseline sigmoidoscopy in the year person turns age 50 and thereafter every 5 years.
- Contraception – Counseling and payment for FDA-approved contraceptive methods, in-network only
- Depression Screening
  - Yearly - adults
- Depression Screening Major Depressive Disorder in Children & Adolescents
  - Yearly - ages 12 to 18
- Developmental/Autism Screening
  - With wellness exam up to age 21
- Diabetes Mellitus Screening (Type 2 Diabetes)
  - Yearly
- Diabetes education provided by a certified diabetic educator or a certified dietician
- Diabetes Mellitus Screening (gestational)
  - All pregnant women (24-28 wks)

- Gonorrhea Screening
  - Yearly - all women
- Hearing Tests
  - Yearly - up to age 21
- Hepatitis B Virus Infection Screening
  - Pregnant women at their first prenatal visit
- HIV – Human Immunodeficiency Virus- Screening
  - All women annually
  - Adolescents & Adults with high risk
- HPV – Human papilloma virus dna test

  - All women beginning age 30 every three years
- Immunizations
  - An immunization that does not fall under one of the exclusions in this Summary Plan Description is considered covered after FDA approval and explicit ACIP recommendation published in the Morbidity & Mortality Weekly Report of the Centers for Disease Control and Prevention.

  Contact UMR for a complete list.
- Lead Screening
  - Yearly - Children through age 6
- Mammography – Screening
  - Yearly all women during the year they turn age 40 and older
- Metabolic Screening Panel
  - One-time newborn (age 0-90 days)
- Newborn Screenings
  - One-time (age 0-90 days) Hearing, Hypothyroidism, Phenylketonuria and Sickle Cell
- Nutritional Counseling to Promote a Healthy Diet
  - For patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

  To determine if your diagnosis qualifies under the Preventive Benefit schedule contact UMR.

  Contact UMR for visits allowed per diagnosis
- Obesity Screening in Adults
  - Yearly
- Obesity Screening
  - Yearly – all covered persons
- Osteoporosis Screening
  - One time for all women 65 and older, or
  - One-time age 60-65 for men or women at high risk equal to or exceeding a 65 year old woman
- RH Incompatibility Screening
  - All pregnant women (each pregnancy)
- Rubella Screening
  - One time lifetime - all women of child bearing age
- Sexually Transmitted Infections – Behavioral Counseling to Prevent
  - Yearly
- Syphilis Screening
  - Yearly - All persons at risk for syphilis infection
  - All pregnant women (each pregnancy)
- TB Testing
  - Yearly - all persons at high risk (as defined by CDC)
- Tobacco Use Counseling/Screening to Prevent Use
  - Yearly - adults
- Visual Impairment in Children - Screening
  - One time between the ages of 3 and 5 years

Surgical Services and Supplies

- Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a surgical procedure.
- Surgeon's expenses for the performance of a surgical procedure.
- Assistant surgeon's expenses, not to exceed 20% of the *usual and customary fee* or, for an *in-network provider*, the *negotiated fee*, of the surgical procedure.
- Circumcision.
- Human organ and tissue transplants, limited to kidney, liver, heart, lung, heart-lung, cornea, pancreas and bone marrow. Approved transplants for *covered person* age 17 or older (at the time of listing for the transplant) will be considered for coverage only when performed at an Aurora Health Care facility. (Exception Review for services applies in-network. See page 11.) Approved transplants for *covered persons* younger than age 17 (at the time of listing for the transplant) will be considered for coverage only when performed at an AACN facility. (Exception Review program applies. See page 11.) High dose chemotherapy or radiotherapy is not a covered benefit unless performed in conjunction with an approved bone marrow transplant or stem cell transplant (and only then in the case of a *covered person* who qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community). Expenses for the donor will be considered if the donor is not eligible under any other group medical plan, insurance plan or government program.
- *Oral surgery* and other covered dental procedures, other than simple tooth extractions. Limited to:
  - Cutting into accessory sinuses, salivary glands or ducts;
  - External/internal incision and drainage of cellulites or abscess;
  - Extraction of seven or more natural teeth at one time;
  - Frenectomy;
  - General anesthesia covered in a *hospital* or *outpatient* facility for a child up to six (6) years old, with a covered dental condition requiring repairs of significant complexity, or for members exhibiting physical, intellectual, or medically compromising conditions.
  - Oral surgery not related to gums;
  - Oral surgery to assist unerupted or malpositioned teeth;
  - Reducing dislocations of the temporomandibular (jaw) joints, including excisions;
  - Removal of bony tumors of the jaws and hard palate;
  - Removal of fully or impacted unerupted teeth when embedded in the bone;
  - Removal of retained (residual) root;
  - Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when a pathological examination is needed;
  - Removal of wisdom teeth;

- Tooth transplantation;
- Treatment for fractured facial bones; and
- Treatment of an accidental *injury* that occurred while covered under the *plan*, to the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Treatment for an accidental *injury* to the teeth must begin within 90 days of the *accident*, unless a delay is *medically necessary* and pre-approved by the AACN medical management team prior to providing the treatment.

- Orthognathic *surgery*.
- *Outpatient surgery*.
- Podiatry services and *surgery*. Routine podiatry services are covered after deductible has been met only for diagnoses of peripheral vascular disease or diabetes and is limited to $150 per calendar year.
- *Reconstructive surgery* for:
  - *Congenital defects* when *surgery* provides functional repair or restoration of any defective body part when repair is necessary to achieve normal body functioning. The defect must have existed at birth. Treatment of port wine stains and other hemangiomas of the head and neck are considered *medically necessary*.
  - Procedures performed to restore the functions of the body, which are lost or impaired due to an *injury* or *illness*.
  - As required under the federal Women's Health and Cancer Rights Act, breast reconstruction following a total or partial mastectomy, including prostheses and reconstruction of the non-diseased breast to restore symmetry and any physical complications resulting from all stages of the mastectomy, including lymphedemas.
- Sclerotherapy/ligation or stripping of varicose veins is a covered benefit only if reviewed and approved as *medically necessary* by the Aurora Medical Management Team.
- Surgical procedures of two or more performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *usual and customary fee* for the largest amount billed for one procedure plus 50% of the *usual and customary fee* or, for *in-network providers*, the *negotiated fee*, for all other procedures performed.
- Surgical reproductive sterilization
- Surgical treatment of *morbid obesity*; limited to one procedure per *lifetime*.
- Surgical treatment of temporomandibular joint dysfunction (TMJ), provided by a *physician* or doctor of dental *surgery* (D.D.S.).

Therapy Services

- Biofeedback.
- Occupational therapy that requires the skills of a qualified, licensed *practitioner* under the supervision of an attending *physician* to restore upper extremity fine motor skills required for independent function in activities of daily living that were lost or impaired as a result of *illness*, *injury* or surgical procedures. Benefits end once treatment is for maintenance therapy.
- *Outpatient* therapy is limited to a total of 60 visits per *year* for

physical, occupational or speech therapy combined.

- Physical therapy that requires the skills of a qualified licensed *practitioner* under supervision of an attending *physician* to restore motor functions needed for activities of daily living that were lost or impaired as a result of illness, injury, or surgical procedures. Benefits end once treatment is for maintenance therapy.
- Speech therapy from a qualified licensed *practitioner,* under supervision of an attending *physician* to restore speech loss due to an *illness*, *injury*, or surgical procedure. If the loss of speech is due to a birth defect, any required corrective *surgery* must have been performed prior to the therapy. Benefits end once treatment is for maintenance therapy.

Treatment Facilities

- *Ambulatory surgical facility*.
- *Birthing center*.
- *Hospice facility*.
- *Mental/nervous treatment facility.*
- *Psychiatric day treatment facility*.
- *Rehabilitation facility*.
- *Residential treatment facility*.
- *Skilled nursing facility*. Confinement must begin within 24 hours of a *hospital* confinement and is limited to 30 days per admission to a maximum of 100 days per calendar *year*.
- *Substance abuse/chemical dependency day treatment facility*.
- *Substance abuse treatment facility*.

Vision Care

One vision exam, excluding lenses, limited to one eye refraction exam per *covered person* per *year*. This vision exam is covered only if rendered by an *in-network provider* and is subject to the annual *deductible*.

Medical Expenses Not Covered

The *plan* will not provide benefits for any of the items listed in this section regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give *you* and *your dependents* a general description of expenses for medical services and supplies not covered by the *plan*. If *you* or *your dependent* has any questions about whether a specific expense will be covered under the *plan*, please contact UMR (for medical) at 1-800-860-5217 or MedImpact (for prescription drugs) at 1-800-788-2949.

Administrative

- Adoption expenses.
- Broken appointments or telephone calls.
- Mailing and/or shipping and handling expenses.
- Preparing medical reports, itemized bills, claim forms or copying and providing medical record information.
- Sales tax.
- Surrogate expenses.

Behavioral

- Counseling services for marital counseling, sex counseling, or bereavement counseling.
- Genetic testing/counseling is not a covered benefit unless reviewed and approved as *medically necessary* by Aurora Medical Management.
- Sanitarium, rest or *custodial care*.
- Smoking cessation programs and products, except as set forth in "What the *Plan* Covers" section of this booklet.

Chemotherapy

- High dose chemotherapy or radiotherapy is not a covered benefit unless performed in conjunction with an approved bone marrow transplant or stem cell transplant (and only then in the case of a *covered person* who qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community).

Cosmetic/Prosthetic

- Body piercing and/or subsequent complications resulting from that procedure.
- Complications arising from any non-covered *surgery*, procedure, service or treatment.
- *Cosmetic surgery, procedures or treatment*.
- Expenses for or related to the removal of prosthetic or breast implants that were: (a) inserted in connection with *cosmetic surgery*, regardless of the reason for removal; or (b) not inserted in connection with *cosmetic surgery*, and the removal of which is not currently *medically necessary*.
- Penile prosthetic implants and/or devices used in the treatment of erectile dysfunction/impotency.
- Skin abrasion procedures associated with removal of actinic changes and/or which are performed as treatment for acne.

- Transsexual *surgery* or any treatment (medical, surgical or pharmaceutical) leading to or connected with transsexual *surgery*.
- Wigs and/or artificial hairpieces.

Dental

- Non-surgical dental services and treatment provided by a *physician* licensed to perform dental services, whether or not services are considered to be medical or dental in nature, except as set forth in the "What the *Plan* Covers" section.
- Non-surgical treatment for, or prevention of, conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint, including but not limited to temporomandibular joint dysfunction (TMJ) and craniomandibular disorder.
- Tooth implant(s) and all related services.

Drugs

- *Prescription drugs* for *outpatient* treatment, except as set forth in the "What the *Plan* Covers" section of this booklet, including but not limited to:
  - Desensitizing agents;
  - Drugs that are not approved by AACN;
  - Drugs used for the treatment of impotency;
  - Drugs used to treat or prevent hair loss;
  - *Experimental* and *investigational* drugs labeled "Caution—limited by Federal law to *investigational* use";
  - Non sedating antihistamine prescription drugs
  - Nutritional supplements, whether or not a *physician* prescription is required;
  - Over-the-counter medicines and supplies that do not require a *physician's prescription drug* order or refill by federal or state law;
  - *Prescription drugs* dispensed in excess of the *plan sponsor's* day supply limit; and
  - Vitamins (except therapeutic vitamins where approved by AACN and an over-the-counter alternative is not available).

Educational

- Education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.
- Educational, vocational or training services and supplies.

Fertility

- Drugs used to induce fertility.

Foot Care

- Non-surgical treatment of the feet, including treatment of corns, calluses and toenails or other routine foot care, except as set forth in the "What the *Plan* Covers" section of this booklet.

Miscellaneous

- Complications arising from any non-covered *surgery,* procedure, service or treatment.
- Condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and

that could entitle the *covered person* to a benefit under the Worker's Compensation Act or similar legislation.

- Condition or disability sustained as a result of being engaged in a(n):
  - Commission or attempted commission of an assault or other illegal act;
  - Duty as a member of the armed forces of any state or country;
  - Illegal occupation;
  - Participation in a civil revolution or a riot; or
  - War or act of war which is declared or undeclared.
- *Elective hospital admissions*, such as an admission on the day prior to the date the *hospital* service will be performed.
- *Eligible expenses* exceeding the *plan* maximums and other benefit limits.
- Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone and guest meals.
- *Third surgical opinions*.

Services/Supplies/Treatment

- Abortions - elective.
- Acupuncture.
- Artificial Heart - Insertion or maintenance of.
- Clothing and equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, light therapy devices, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.
- *Experimental/investigational* medical services, supplies, or treatment.
- Medical services, supplies, or treatment under a Health Maintenance Organization (HMO) if the *covered person* is a *covered person* in the HMO.
- Hypnosis.
- Medical services, supplies, or treatment eligible for consideration under any other plan of the *employer*.
- Medical services, supplies, or treatment rendered by a provider outside the AACN exceeding the *usual and customary fee* charged by providers in the geographic area where the medical services, supplies, and treatment are rendered.
- Medical services, supplies or treatment otherwise covered under the *plan*, but rendered to a *covered person* prior to the effective date or after the termination date of the *covered person's* coverage under the *plan*. This includes medical services, supplies or treatment for medical conditions arising prior to the date the *covered person's* coverage terminates under the *plan*.
- Medical services, supplies or treatment for which there is no legal obligation to pay, or expenses, which would not be made, except for the availability of benefits under the *plan*.
- Medical services, supplies, or treatment furnished by or for the United States government or any other government, unless payment is legally required, furnished, and paid for, or for which benefits are provided or required by reason of past or present service of any

covered family member in the armed forces of a government.

- Medical services, supplies or treatment not *medically necessary*, except as otherwise specified in this document.
- Medical services, supplies or treatment rendered by anyone other than a covered *health care provider*.
- Medical services, supplies or treatment not prescribed or recommended by a *health care provider*.
- Medical services, supplies or treatment for pre-existing conditions as set forth in the Eligibility and Participation section of this booklet.
- Private-duty nursing.
- Professional services performed by a person who ordinarily resides in *your* household or is related to the *covered person*, such as a *spouse*, parent, or *dependent* child.
- Radiation therapy. High dose radiotherapy is not a covered benefit unless performed in conjunction with an approved bone marrow transplant or stem cell transplant (and only then in the case of a *covered person* who qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community).
- Rapid cardiac CT scans.
- Reversal of any reproductive sterilization procedure.
- Sclerotherapy/ligation or stripping of varicose veins is not a covered benefit unless reviewed and approved as *medically necessary* by the Aurora Medical Management Team.
- Sleep disorder treatment, except as set forth in the "What the *Plan* Covers" section of this booklet.
- Surrogate Services including services and expenses related to conception, pregnancy, delivery, or post-partum care in connection with a *Surrogate Arrangement*.
- Transplants of animal to human or artificial or mechanical devises designed to replace human organs.

Therapy

- Auditory Integration Therapy
- Augmentative/Alternative Communication Therapy
- Conductive Therapy
- Equestrian Therapy
- Hippotherapy
- Exceptional educational needs - under Wisconsin state law local public school systems are mandated to provide therapies that meet the exceptional educational needs of children age 3 through 21. Therefore, coverage for such services are excluded under the medical *plan*.
- Massage therapy or rolfing.
- Occupational therapy supplies.
- Recreation Therapy
- Sensory Integration Therapy
- Social Interaction/Integration Therapy
- Speech therapy, except as set forth in the "What the *Plan* Covers" section of this booklet.
- Therapy (speech, occupational and physical) for:

- Vocational rehabilitation, including work hardening programs;
- Educational, counseling, job training;
- Physical fitness or exercise programs; and
- Maintenance therapy (as determined by Aurora Medical Management) where there is no reasonable expectation that services will provide significant measurable improvement in the patient's condition in a reasonable and generally predictable and finite period of time.

Travel

- Medical services, supplies, or treatment provided outside the United States or its territories, except for in the case of an accidental *injury* or a *medical emergency*.
- Travel or transportation expenses of a *physician* or a *covered person*, except ambulance services as set forth in the "What the *Plan* Covers" section of this booklet.
- Vaccines and immunizations related to work or travel are not covered.

Vision

- Fitting of eyeglasses or contact lenses, except with replacement of human lens lost through intraocular *surgery* as set forth in the "What the *Plan* Covers" section of the booklet.
- Kerato-refractive eye *surgery* (to improve near sightedness, far sightedness, and/or astigmatism by changing the shape of the cornea) including, but not limited to, radial keratotomy and keratomileusis *surgery*.

Weight Control

- Non-surgical treatment of *morbid obesity*, except as set forth in the "What the *Plan* Covers" section of this booklet.
- Drugs used for weight reduction or control.
- Weight reduction or control treatment, instructions, activities or drugs, including diet pills, except as set forth in the "What the *Plan* Covers" section of this booklet.
- Weight control or reduction programs such as, but not limited to, food supplements, Jenny Craig and Weight Watchers, membership in health clubs or YMCAs or weight loss medications.

Coordination of Benefits

General Provision

Coordination of benefits applies when *you* and/or *your dependent*(s) (including *domestic partners* and children of *domestic partners*) are covered under more than one group plan.

With regard to coordination of benefits, other group plans shall mean:

1. Group, blanket, or franchise insurance coverage, except for Health Maintenance Organizations as noted below;

2. Service plan contracts, group or individual practice, and other prepayment coverage;

3. Coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

4. Casualty or liability coverage;

5. *Medicare* or other governmental programs, as permitted by law.

The term “group plan” does not include coverage under individual policies or contracts.

The group plan assuming primary payer status will determine benefits first without regard to benefits provided under any other group medical plan.

When this *plan* is the secondary payer, it will reimburse, subject to all *plan* provisions, the balance of remaining *eligible expenses,* not to exceed normal *plan* liability if this *plan* had been primary.

This *plan* is secondary for *retirees* eligible for *Medicare*, whether or not they have applied for it.

For purposes of coordination, *eligible expense* means any *usual and customary fee* or, for *in-network providers*, the *negotiated fee* considered in part or full by this *plan*.

This *plan* will not coordinate benefits with coverage provided by a Health Maintenance Organization (HMO) even if denied. This *plan* will not coordinate benefits with automobile insurance.

Children of Divorced or Separated Parents

When all *plans* covering a person as a *dependent* child of divorced or separated parents contain a coordination of benefit provision, the order of payment will be:

- The *plan* covering the *dependent* child of the parent designated by court order to be responsible for the child’s medical care expenses will be considered the primary payer.
- In the absence of a court order specifying otherwise, the *plan* covering the child as a *dependent* of the parent having primary legal custody of the child will be considered the primary payer. If the parents have joint (equal) legal custody, the primary payer will be

the parent with the earlier birth date (month and day) in the calendar year. If both parents have the same birth date, the *plan* covering the dependent child for the longer period of time will be the primary payer.

- In the absence of a court order specifying otherwise, the *plan* covering the *dependent* child of a stepparent who is the *spouse* of the parent having primary legal custody of the child will be considered the primary payer.

Government Programs

The term "group medical plan" includes, but is not limited to, the government programs *Medicare*, Medicaid and TRICARE. The regulations governing these programs take precedence over the determination of this *plan*. For example, in determining the benefits payable under the *plan*, the *plan* will not take into account the fact that *you* or any eligible *dependent*(s) are eligible for or receive benefits under a Medicaid plan. The *plan* will honor any medical assignment of rights made by or on behalf of *you* and/or *your dependents* covered under the *plan*. The *plan* will also honor any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for expenses covered by this *plan*. In a situation where the law provides that this *plan's* coverage is secondary to *Medicare*, this *plan's* benefits are secondary to *Medicare* even if the person eligible for *Medicare* fails to apply for *Medicare* or fails to make a due claim for benefits.

Other Group Plans

Any group medical *plan* that does not contain a coordination of benefits provision will be considered the primary payer. When all *plans* covering *you* and/or *your dependent*(s) contain a coordination of benefits provision, order of payment will be as follows:

- The *plan* covering a person as an active *employee* will be the primary payer over a *plan* covering the same person as a *dependent*, a *retiree* or a laid-off individual. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefit determination, then this rule will not apply.
- When a *covered person* is an active *employee* under more than one *plan*, the *plan* of the *employer* for which *you* are regularly scheduled to work the greatest number of hours will be considered the primary payer over the *plan* of any other *employer* for which *you* are regularly scheduled to work a lesser number of hours. If a *covered person* is scheduled to work an equal number of hours under two or more *plans*, the *plan* covering the person for the longer period of time will be considered the primary payer.
- The *plan* covering a person as an active *employee* or a *dependent* will be the primary payer over the *plan* providing continuation coverage (COBRA).
- The *plan* covering a person on an extension of benefits for total disability pursuant to applicable state insurance law will be primary payer over the *plan* covering the person as a succeeding *plan*.
- A *plan* covering a person as a *dependent* child of non-divorced or non-separated parents will be the primary payer according to which parent has the earlier birth date

(month and day) in the calendar *year*. If both parents have the same birth date, the *plan* covering the *dependent* child for the longer period of time will be the primary payer.

- See above for rules for *dependents* of divorced or separated parents.
- When the above rules do not establish the order, the benefits of the *plan* which has covered the person for whom claim is made for a longer period of time will be determined before the *plan* which has covered the person for the shorter period of time.

Right to Make Payments to Other Organizations

Whenever payments that should have been made by this *plan* have been made by any other plan(s), this *plan* has the right to pay the other *plan(s)* any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this *plan* and, to the extent of such payments, the *plan* will be fully released from any liability regarding the person for whom payment was made.

Other Important Plan Provisions

Alternate Payee Provision

Under normal conditions, benefits for *hospital* and *in-network provider* expenses are paid directly to the provider of services or supplies. All other benefits are payable to the *covered person* and can be paid to another party only upon signed authorization from the *covered person* (or the *covered person's* parent or legal guardian). If conditions exist under which a valid release or assignment cannot be obtained, the *plan* may make payment to any individual or organization that has assumed the care or principal support for the *covered person* and is equitably entitled to payment. The *plan* must make payments to *your* separated or divorced *spouse*, state child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

The *plan* may also honor benefit assignments made prior to a *covered person's* death in relation to remaining benefits payable by the *plan*. Any payment made by the *plan* in accordance with this provision will fully release the *plan* of its liability to that *covered person*.

Assignment of Benefits

All *in-network provider* benefits payable by the *plan* are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All benefits payable for *hospital* expenses are automatically assigned to the providing *hospital*. All other benefits provided by the *plan* may be assigned at a *covered person's* option only to the treating *health care provider*. Payments made in accordance with an assignment are made in good faith and release the *plan's* obligation to the extent of payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan. Other than assignment of benefit payments to *health care providers*, benefit payments or any other rights (specifically including your right to appeal or bring a lawsuit following an adverse benefit determination) under the *plan* are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind.

Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this *plan*, the *plan* has the right to recover these payments from any individual (including *yourself* or another *covered person*), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered. If excess payments were made for services rendered to *your dependent*(s), the *plan* has the right to withhold payment on *your* (or *your dependent's)* future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by *you* or *your dependents*, the *plan* will exercise all available legal rights, including but not limited to its right to withhold payment on future

benefits until the overpayment is recovered.

Right to Receive and Release Necessary Information

The *plan* may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement *plan* provisions subject to the privacy regulations under the Health Insurance Portability and Accountability Act ("HIPAA") as described later in this booklet. When a *covered person* requests benefits, the *covered person* must furnish all the information required to implement *plan* provisions. Failure to provide such information may result in a delay of benefit payments, or may result in no benefits being paid.

Special Election for Employees and *Spouses* Age 65 and Over Who Have Current Employment Status

If *you* remain *actively* employed after reaching age 65, *you* or *your spouse* may choose to remain covered under this *plan* without reduction for *Medicare* benefits or designate *Medicare* as the primary payer of benefits. If *you* choose to remain covered under this *plan*, the *plan* will be the primary payer of benefits and *Medicare* will be secondary. If *you* choose *Medicare* as primary, coverage under the *plan* will end. If *you* do not specifically choose one of the options, the *plan* will continue to be primary. If *you* are under age 65 and *your spouse* is over age 65, he or she can make his or her own choice.

Subrogation

This section applies whenever another party (including *your* own insurer under an automobile or other policy) is legally responsible or agrees to compensate *you* or *your dependent* for *your* (or *your dependent*'s) *illness* or *injury* and the *plan* has paid benefits related to that *illness* or *injury*. The *plan* is subrogated to all the rights of *you* or *your dependent* against any party liable for *your* (or *your dependent*'s) *illness* or *injury* to the extent of the benefits provided to *you* or *your dependent* under the *plan*. The *plan* may assert this right independently of *you* or *your dependent*. The *plan's* right of subrogation is to full recovery. It may be made from any responsible or liable party, including the *employer,* under the provisions of a Worker's Compensation or Occupational Disease law.

You or *your dependent* (or the *covered person's* estate or guardian) is obligated to cooperate with the *plan* and its agents in order to protect the *plan's* subrogation rights. Cooperation means providing the *plan* or its agents with any relevant information requested by them, signing and delivering such documents as the *plan* or its agents reasonably request to secure the *plan's* subrogation claim, and obtaining the consent of the *plan* or its agents before releasing any party from liability for payment of medical expenses. *You* are obligated to notify the *plan administrator* in writing whenever benefits are paid or are payable under this *plan* that arise out of an *illness* or *injury* that provides or may provide the *plan* subrogation or reimbursement rights.

If *you* or *your dependent* enters into litigation or settlement negotiations regarding the obligations of other parties, *you* or *your dependent* must not prejudice, in any way, the subrogation rights of the *plan* under this section. The cost of legal representation of the *plan* in matters related to subrogation will be born solely by the *plan*. The cost of legal representation of *you* or *your dependent*

must be born solely by *you* or *your dependent*.

The Plan's Right to Reimbursement

This section applies whenever another party (including *your* own insurer under an automobile or other policy) is legally responsible or agrees to compensate *you* or *your dependent*, by settlement, verdict or otherwise, whether or not liability is admitted by a third party for an *illness* or *injury* and the *plan* has paid benefits related to that *illness* or *injury*. In that case, *you* or *your dependent* (or the legal representatives, estate or heirs of either *you* or *your dependent*) must promptly reimburse the *plan* for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether *you* or *your dependent* has been made whole). You or *your dependent* (or the legal representatives, estate or heirs of either *you* or *your dependent*) will be considered to hold the amount to be reimbursed to the *plan* in constructive trust for the benefit of the *plan*. If the *plan* has not yet paid benefits relating to that *illness* or *injury*, the *plan* may reduce or deny future benefits on the basis of the compensation received by *you* or *your dependent*.

This right of reimbursement is in addition to the subrogation rights of the *plan*. By accepting benefits under this *plan*, the injured party acknowledges that the *plan* has a right to recover amounts representing the *plan's* subrogation or reimbursement interest through any appropriate legal remedy, or equitable remedy, including the imposition of a constructive trust or a claim of equitable restitution against any recipient of monies recovered through settlement, judgment or otherwise. The *plan's* subrogation or reimbursement interest, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

In order to secure the rights of the *plan* under this section, *you* or *your dependent* hereby: (1) grant to the *plan* a first priority lien against the proceeds of any such settlement, verdict or other amounts received by *you* or *your dependent*; and (2) assign to the *plan* any benefits *you* or *your dependent* may have under any automobile policy or other coverage, to the extent of the *plan's* claim for reimbursement.

You or *your dependent* must cooperate with the *plan* and its agents, and must sign and deliver such documents as the *plan* or its agents reasonably request to protect the *plan's* right of reimbursement. *You* or *your dependent* must also provide any relevant information, and take such actions as the *plan* or its agents reasonably request to assist the *plan* in making a full recovery of the reasonable value of the benefits provided. *You* or *your dependent* must not take any action that prejudices the *plan's* right to reimbursement. The reimbursement required under this provision will not be reduced to reflect any costs or attorney fees incurred in obtaining compensation unless separately agreed to, in writing, by the *plan administrator*, in the exercise of its sole discretion.

The *plan's* reimbursement and subrogation rights shall have priority over any other competing claims regardless of whether the total amount of the recovery of the *covered person* is less than the actual loss suffered, or less than the amount necessary to make the *covered person* whole. Failure to comply with these subrogation

and reimbursement rules of the *plan* may, at the *plan administrator's* discretion, result in a forfeiture of benefits under this *plan*.

All references to *you* or *your dependent* in the sections describing the *plan's* rights to subrogation and reimbursement include the *covered person's* estate, guardian, heirs or legal representatives.

This *plan* excludes coverage for any *injury or sickness* that is eligible for benefits under Worker's Compensation. If benefits are paid by the *plan* and *you* receive Worker's Compensation for the same incident, the *plan* has the right to recover. That right is described in this section. The *plan* reserves its right to exercise its recovery rights against *you* even though:

1. The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the *injury or sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Worker's Compensation due to health care expense is not agreed upon or defined by *you* or the Worker's Compensation carrier; or

4. The health care expense is specifically excluded from the Worker's Compensation settlement or compromise.

Governing Law

To the extent not preempted by federal law, this *plan* shall be interpreted and applied in accordance with the laws of the State of Wisconsin, as amended from time to time.

Illegality of Particular Provision

The illegality of any particular provision of the *plan* shall not affect any other provisions, but the *plan* shall be construed in all respects as if such invalid provision were omitted.

Discretionary Authority

Benefits under this *plan* will be paid only if the *plan administrator* decides in its discretion that the *covered person* is entitled to benefits. The *plan administrator* will have full discretion to interpret *plan* terms; supply omissions or reconcile inconsistencies in the *plan* terms; make decisions regarding eligibility; and resolve factual questions. The discretion will apply with respect to all claim payments and benefits under the *plan*. The *plan administrator* also has the discretion to establish rules and procedures for operation of the *plan*, and can authorize more detailed supplements to or schedules of benefits under the *plan* than are provided in this summary. In such a case, those rules, procedures, supplements or schedules will be considered part of the *plan*.

Not a Contract of Employment

This *plan* does not constitute a contract of employment between the *employer* and any *covered person*.

Privacy

Effective April 14, 2004 under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the *employer,* who is the sponsor of this *plan,* will receive protected health information. The information may identify the individual in some cases. The *employer* is limited in how it may use this information. Its uses and disclosures must be necessary to carry out *plan* functions. The *plan* functions must relate to payment or health care

operations, as defined in the Privacy Regulations under HIPAA. Please see the attached HIPAA Privacy Statement in Appendix A for more information on *your* privacy rights under HIPAA.

Pronouns

All personal pronouns used in the *plan* include either gender. This will be true unless its use clearly indicates otherwise.

Worker's Compensation

This *plan* is not issued in lieu of Worker's Compensation coverage. It does not affect any requirement by any Worker's Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.

How to File Claims

Filing and Processing a Claim Medical Claim (Excluding *Prescription Drugs*)

Generally, *your health care provider* should file claims for *you* or *your dependent*. Electronically submitted claims are processed most efficiently. If *your health care provider* is unable to file *your* claim electronically with UMR, the following claim forms must be filed, depending on the medical services rendered:

- HCFA-1500 (revision 12/90 and later) form for any medical expense;
- UB-92 form for any *hospital* expense; and/or
- Vision care submittal forms.

These are the only appropriate forms for requesting *plan* payment. If *your health care provider* is unable to file one of these forms for *you* or *your dependent*, *you* or *your dependent* are responsible for completing and submitting one to UMR. These forms are available from *your health care provider, employer*, or the Employee Connection. *You* or *your dependent* will be required to include the following information on *your* claim for benefits:

- *Employee's* name, identification number and address;
- Patient's name, identification number and address (if different from the *employee's*);
- Provider's name, tax identification number, address, degree and signature;
- Date(s) of service;
- Diagnosis;
- Procedure code(s) (this code describes the treatment or medical service rendered);
- Assignment of benefits, signed (if payment is to be made to the provider);
- Release of information statement, signed; and/or
- Explanation of Benefits (EOB) information if another *plan* is the primary payer.

Claims should be submitted to UMR for each *covered person* at the address below. Please do not attach or staple claims together. If additional information is needed to process a claim, *you* or *your dependent* or *your health care provider* will be notified. If *you* receive a letter regarding *your* claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim.

When *your* (or *your dependent's)* claim has been processed, *you* will receive an Explanation of Benefits (EOB) statement describing how much of the medical expenses have been paid under the *plan*. If *you* or *your dependent* have questions on how *your* claim was processed, call or write:

UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541
1-800-860-5217

All claims must be filed with the *plan* within a one-*year* period from the date the service was performed or the service or supply was purchased to be considered a covered expense under the *plan*. Claims filed after this deadline will not be paid.

Prescription Drug Claim

In-Network Provider

You may purchase a *prescription drug* with a *co-insurance* as set forth in the "Summary of Benefits" in the beginning of this booklet at any of the pharmacies in the AACN. *You* are not required to submit a claim form to MedImact Healthcare Systems, Inc., our *prescription drug* administrator; the pharmacy should file the claim for *you*. To obtain a *prescription drug* at any pharmacy in the AACN, present *your* AACN medical card to the pharmacist.

Out-of-Network Provider

You will be responsible for payment of *prescription drugs* dispensed by a pharmacy out of the AACN at the time of *your* purchase. Reimbursement of *prescription drug* expenses paid by *you* at the time of purchase (less *your* share of the cost as set forth in the "Summary of Benefits" page in the beginning of this booklet) can be obtained by filing a claim with:

MedImpact Healthcare Systems, Inc.
10680 Treena Street, Stop 5
San Diego, CA 92131
1-800-788-2949

Prescription drug claim forms are available online through the Employee Connection, Get A Form.

Initial Decision of Your Claim

You or *your* Authorized Representative may file a claim for benefits under the *plan*. See the section on an Authorized Representative later in this booklet. The period of time for deciding a claim will begin when a claim is filed in accordance with the claim filing procedures of the *plan*, without regard to whether all the information necessary to decide the claim accompanies the filing. If the time period is extended due to *your* (or your dependent's) failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to *you* or *your dependent* to the date the *plan* receives *your* (or *your dependent's)* response to the request. For the purposes of these claims procedures, days are measured in calendar days. Additionally, the *plan* relies on a general presumption that a notice sent by first class mail will be received within five business days.

How *you* or *your dependent* files an initial claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

Urgent Care Claim

An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating *physician*, lack of immediate processing of the claim could seriously jeopardize the life or health of *you* or *your dependent* or subject *you* or *your dependent* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. If *your* (or *your dependent's)* claim involves urgent care, *you, your dependent* or *your* Authorized Representative will be notified of the *plan's* initial decision on the claim as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the *claims administrator* to make a decision, *you*, *your dependent* or your Authorized Representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. *You* or *your dependent* will have at least 48 hours to respond to this request; the *plan* then must inform *you* or *your dependent* of its

decision within 48 hours of receiving the additional information.

Concurrent Care Claim
A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. If *your (*or *your dependent's)* claim is one involving concurrent care, the *plan* will notify *you* or *your dependent* of its decision within 24 hours after receiving the claim, if the claim was for urgent care and was received by the *plan* at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. *You* or *your dependent* will be given time to provide any additional information required to reach a decision. If *your* (or *your dependent's)* concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the *plan* will respond according to the type of claim involved (i.e., other post-service).

Post-Service Care Claim
A post service claim is a claim for payment or reimbursement after services have been rendered. If *your* (or *your dependent's)* claim is for a post-service reimbursement or payment of benefits, the *claims administrator* will notify *you* or *your dependent* within 30 days of receipt of the claim if the claim has been denied or if further information is required. The 30 days can be extended to 45 days if the *claims administrator* notifies *you* or *your dependent* within the initial 30 days of the circumstances beyond the *plan's* control that require an extension of the time period, and the date by which the *plan* expects to make a decision. If more information is necessary to decide a post-service claim, the *plan* will notify *you* or *your dependent* of the specific information necessary to complete the claim. *You* or *your dependent* will be given at least 45 days from the receipt of the notice to provide the necessary information. If *you* or *your dependent* return the necessary information within the time allotted the *claims administrator* will decide *your* (or *your dependent's)* claim within 15 days of the date that it receives the information. If *you* or *your dependent* do not return the specified information within the time allotted, *your* (or *your dependent's)* claim will be processed within 15 days of the deadline based on the information in the *claims administrator's* possession at such time, which may result in a denial. If your claim is denied, y*ou* or *your dependent* then can appeal the decision as described below.

Notice of Claim Denial

If the *claims administrator* partially or wholly denies *your* (or *your dependent's)* claim for benefits, *you* or *your dependent* will receive an explanation of benefits (EOB) that will include the information required by law, including:

- The specific reason or reasons for the denial;
- Reference to the specific provisions of the *plan* document on which the denial is based;
- A description of any additional material or information which *you* or *your dependent* must provide to perfect the claim, and an explanation of why that material or information is needed;
- A description of the steps *you* or *your dependent* must take to appeal

the denial of the claim and the time limits applicable to such procedures; and

- *Your* (or *your dependent's)* right to bring civil action under ERISA after the appeal if *you* disagree with the appeal decision.

In addition, if the *claims administrator* denies the claim, *you* or *your dependent* will be notified if the *claims administrator* relied in whole or in part on any internal rule, guideline, protocol or other similar criterion in making the adverse determination. *You* or *your dependent* may request a copy of the pertinent rule, etc., free of charge. In addition, *you* or *your dependent* will be notified if the *claims administrator* relied in whole or in part on *medical necessity* or *experimental/investigational* treatment or a similar limit or exclusion. *You* or *your dependent* may request free of charge the scientific or clinical judgment for the determination which applies the terms of the *plan* to the claimant's medical circumstances.

If the claim is denied in whole or part, *you* or *your dependent* may file a request for appeal, as described in the next section.

Appealing a Denied Claim

If *you* believe a claim was decided improperly, *you* or *your dependent* or an Authorized Representative (see below) may file a written appeal of the denial with the *claims administrator* no later than 180 days after *you* or *your dependent* receive the notice that *your* claim has been partially or wholly denied. In *your* (or *your dependent's)* appeal letter, *you* should provide the reasons why *you* or *your dependent* disagree with the benefits determination and include any documentation *you* or *your dependent* believe supports *your* (or *your dependent's)* claim. Be sure to include *your* (or *your dependent's)* name and social security number. *You* or *your dependent* may include any issues, comments, statements or documents that *you* wish to provide with *your* written appeal. Upon request and free of charge, *you* or *your dependent* or an Authorized Representative may have reasonable access to, and copies of, all documents, records and other information relevant to *your* (or *your dependent's)* claim for benefits when preparing *your* (or *your dependent's)* request.

The following rules also apply: (a) the appeal review will not be conducted by the same individuals, or a subordinate of the individual, who made the initial determinations; (b) the review will be conducted without giving deference to the initial denial; (c) if the decision is based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same individual who was consulted in the initial determination and is not a subordinate of that individual; (d) upon request, any medical or vocational experts whose advice was obtained in behalf of the *plan* in connection with *your* appeal review will be identified by name; and (e) the review will consider all information submitted, regardless of whether it was considered during the initial determination.

Timetable for Deciding Appeals

The *plan administrator* must issue a decision on *your* (or *your dependent's)* appeal according to the following timetable:

- Urgent Care Claims - not later than 72 hours after receiving *your* (or *your dependent's)* request for a review.
- Post-Service Claims - not later than 60 days after receiving *your* (or *your dependent's)* request for a review.
- Concurrent Claims - decisions will be issued on concurrent claim appeals within the time-frame appropriate for the type of concurrent care claim (i.e., urgent or post-service).

Notice of Denial on Appeal

If *your* (or *your dependent's)* appeal for benefits is denied (partially or completely), *you* or *your dependent* will receive a written notice that will include all information required by law, including:

- The specific reason or reasons for the denial;
- Specific references to pertinent provisions of the *plan* document on which the denial is based;

- A notice of *your* (or *your dependent's)* right, upon request and free of charge, to have reasonable access to, and copies of, all documents, records and other information relevant to *your* (or *your dependent's)* claim for benefits;
- A description of any voluntary appeal procedures offered by the *plan* and *your* (or *your dependent's)* right to obtain information about the procedures; and
- A notice of *your* right to bring civil action under ERISA or to appeal to an external independent review organization.

If the denial is based on a finding that services or supplies are not *medically necessary* or involve *experimental* treatment or a similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment that is the basis for the denial, applying the terms of the *plan* to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. *You* will be notified if the denial relied on any internal rule, guideline, protocol or other special criterion in making the adverse determination. *You* or *your dependent* may request a copy of the pertinent rule, etc., free of charge.

Filing an Appeal
All written requests for a review of denied medical claims (excluding *prescription drug* benefits) should include a copy of the explanation of benefits (EOB) and any other pertinent information. Send all information to:

UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541
1-800-860-5217

All written requests for a review of *prescription drug* benefits should include all pertinent information. Send all information to:

MedImpact Healthcare Systems, Inc.
10680 Treena Street, Stop 5
San Diego, CA 92131
1-800-788-2949

Requests for an appeal that does not comply with this procedure will not be considered, except in extraordinary circumstances. The *claims administrator* has full discretionary authority to make decisions on eligibility for benefits under this *plan* and to construe the terms of this *plan* for this purpose.

Rights after Adverse Appeal Decision

If the appeal is denied and *you* or *your dependent* are not satisfied with the results, then *you* or *your dependent* may:

- Bring a suit for benefits. *You* or *your dependent* must file any legal action within 270 days of receiving the adverse appeal notice under these procedures.

  OR

- Request a review by an external independent review organization (IRO), if the adverse appeal decision involved medical judgment or a rescission of coverage. Examples of adverse appeal decisions involving medical judgment include, but are not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. An example of an adverse appeal

decision involving rescission includes, but is not limited to, a retroactive termination of coverage for someone *you* enrolled as *your domestic partner* but who did not qualify as *your domestic partner* under the terms of the *plan*.

You or *your dependent* may not begin any legal action, including proceedings before administrative agencies, until *you* have followed these procedures and exhausted the opportunities described in this section. *You* are not required, however, to request a review by an IRO prior to beginning a legal action. A request for review by an IRO is completely voluntary.

If *you* or *your dependent* do request a review by an IRO and the IRO denies the claim, then *you* or *your dependent* are still entitled to bring a suit for benefits in court. Note, however, that the requirement to file suit within 270 days from the date of receiving the adverse appeal decision from the *plan* still applies. The 270 day period does NOT run from the date you receive an adverse decision from the IRO.

Voluntary Appeal to External Independent Review Organization (IRO)

To file a request for review by an IRO, *you* or *your dependent* must make a written request within four months from *your* receipt of notice of the plan's final adverse appeal decision. If there is no corresponding date four months after the date of receipt of such notice, then *your* or *your dependent's* request for external independent review must be filed by the first day of the 5th month following receipt of such 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. The notice of the final adverse appeal decision will provide information about where to file a request for an independent external review. If *you* or *your dependent* do not timely file a request for an IRO review by the deadline, the only recourse will be to file a lawsuit under ERISA.

Upon receipt of the request for external independent review, the *plan administrator* will conduct a preliminary review within five days to confirm that:

- The claimant was covered under the *plan* at the time the item or service was requested, or in the case of a retrospective review, was covered under the *plan* at the time the item or service was provided;
- The medical benefit denial does not relate to the claimant's failure to meet the *plan's* eligibility requirements;
- The claimant has exhausted the *plan's* internal appeals process (unless it is an expedited review, which is described in more detail below); and
- The claimant has provided all information necessary to process the external independent review.

Within one business day after the completion of the preliminary review, the *plan administrator* will notify *you* or *your dependent* of one of the following:

- That the request is complete, but not eligible for consideration by an external IRO because not all of the requirements described above were satisfied. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.

- That the request is incomplete, but may still be eligible for consideration by an external IRO. This notice will describe the information or materials needed to complete the request. *You* or *your dependent* will be permitted to provide the required information by the later of: (1) the last day of the four-month filing period or (2) 48-hours after receipt of the notice.
- That the request is complete and eligible for consideration by an external IRO.

If the request is complete and eligible for consideration by an external IRO, then the claim, along with all documentation, will be referred to an accredited external IRO. The external IRO will determine if the claim relates to medical judgment or a rescission of coverage. If the external IRO determines that the claim does not meet these requirements, then the external IRO will not review the claim.

If the external IRO will review the claim, the plan will provide the assigned IRO with the documents and any information considered in making the final adverse benefit determination. *You* or *your dependent* may submit additional information to the IRO conducting the review within 10 business days following *your* receipt of the notice from the *plan administrator* that the request has been assigned to external review. Upon receipt of the claim, the IRO will review all relevant documentation. The IRO is not bound by the *plan's* original decision when making its review.

Within 45 days after the IRO receives the external review request, it will provide written notice of the final review decision to *you* or *your dependent* and the *plan administrator*. If the IRO determines that the claim should be denied, then *you* or *your dependent* may file a lawsuit under ERISA for benefits. If the IRO determines that the claim should be paid, then the *plan* will promptly make payment. However, the *plan administrator* may decide to seek a review in court of the IRO's decision.

You or *your dependent* may qualify for an expedited external independent review if (1) *you* or *your dependent* have a medical condition where the timeframe for completion of a standard external independent review would seriously jeopardize *your* life or health, or (2) if the final adverse appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which *you* or *your dependent* received emergency services but have not been discharged from a facility. The external independent review process is the same for expedited reviews except that:

- The *plan administrator* must conduct the preliminary review immediately, instead of taking five days for the review;
- If eligible, the claim is immediately referred to an IRO; and
- The IRO will review the claim and communicate its decision no later than 72 hours after receipt of the external independent review documentation.

Appointing an Authorized Representative

If *you* or *your dependent* wish to have someone act on *your* behalf for purposes of filing claims, making inquiries and filing appeals, *you* or *your dependent* must furnish the *claims administrator* with a written designation of *your* Authorized Representative. Once *you* appoint an Authorized Representative in writing, all subsequent communications regarding *your* claim

will be provided to *your* Authorized Representative.

You or *your dependent* may, at *your* own expense, have legal representation at any stage of these review procedures.

Optional Continuation of Coverage (COBRA Coverage)

Qualifying Events

As mandated by federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the *plan* offers optional continuation coverage to *you* and/or *your dependent*(s) if coverage would otherwise end due to a qualifying event. Although not required under federal law, this *plan* also provides COBRA continuation of coverage benefits to *your domestic partner* or ex-*domestic partner* and the eligible *dependents* of *your domestic partner* or ex-*domestic partner*. Qualifying events under this *plan* include:

- Termination of *your* employment with *your employer* for any reason except gross misconduct. COBRA coverage may continue for *you* and *your* eligible *dependent*(s).
- A reduction in hours worked by *you* or a change to a job where *you* are no longer eligible for benefits. COBRA coverage may continue for *you* and *your* eligible *dependents*.
- *Your* death. COBRA coverage may continue for *your* eligible *dependent*(s).
- Divorce or legal separation from *your spouse*. COBRA coverage may continue for *your* eligible ex-*spouse* and *your* other eligible *dependent*(s). Contact human resources with new address information.
- Termination of a *Domestic Partnership*. Coverage may continue for *your* eligible ex-*domestic partner* and the eligible *dependent(s)* of the ex-*domestic partner*. Contact human resources with new address information.
- *You* become entitled to *Medicare*. Coverage may continue for *your* eligible *dependents*.
- Loss of eligibility by a covered *dependent* child. Coverage may continue for that eligible *dependent* child.
- *Your employer* files a bankruptcy petition under Title XI, United States Code. Coverage may continue for *retirees* and their *dependent*(s) covered under the *plan* if such *retiree* coverage ends or is substantially reduced within one *year* before or after the date the bankruptcy was filed. (Please note that if the *plan* does not cover *retirees* at the time, *employer* bankruptcy is not a qualifying event.)

To choose this continuation coverage, an individual must generally be a "qualified beneficiary." A qualified beneficiary is a *covered person* under the *plan* on the day before the qualifying event or is a child born to or adopted by *you* or placed for adoption with *you* during the period of *your* continuation coverage. *You* must notify the *plan administrator* within 60 days of the birth, adoption or placement for adoption in order to add the child to *your* coverage during the COBRA continuation period.

In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or must be a *dependent* of the retired *employee* on the day before the bankruptcy.

If coverage for similarly situated *employees* or their *dependents* is modified, continuation coverage will be modified in the same way.

Notification and Election Requirement

You or *your dependents* have the responsibility to inform the *plan administrator* in writing at the address provided in this booklet of a divorce, legal separation, a termination of a *domestic partnership*, a child losing *dependent* status covered under the *plan* or a disability initiation or extension within 60 days of the date coverage under the *plan* would otherwise end due to qualifying event. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights. This written notice should include:

- the *employee's* name;
- any other qualified beneficiary's names;
- a description of the event;
- the date of the event; and
- support documentation as noted below.

For a divorce or legal separation, *you* or *your dependent* must include a copy of the divorce decree or court order. For a termination of a *Domestic Partnership*, *you* or *your dependent* must provide an affidavit of Termination of *Domestic Partnership*. To substantiate a child's loss of dependency status, *you* or *your dependent* must include proof of age or loss of that status or other applicable documentation. For initiating or ending a disability extension, *you* or *your dependent* must provide the final determination letter from the Social Security Administration.

You or *your dependent* should keep a copy of any notices *you* send to the *plan administrator* for *your* own records. If *you* or *your dependent* are not an eligible qualified beneficiary or an event does not constitute a qualifying event, the *plan administrator* will notify *you* or *your dependent* that COBRA coverage is unavailable.

Your employer has the responsibility of notifying the *plan administrator* of *your* death, termination of employment, reduction in hours or change to ineligible status, or entitlement to *Medicare* or the *employer's* bankruptcy within 30 days of the qualifying event.

The *plan administrator* will notify *you* and other qualified beneficiary(ies) of continuation coverage rights or their unavailability within 14 days of the notice described above. If eligible, *you* and any other qualified beneficiary(ies) will then have 60 days to elect continuation coverage. Failure to elect continuation coverage within this 60-day period after being notified by the *plan administrator* will result in loss of continuation coverage rights**.** Please contact UMR at 800-207-1824 if for some reason *you* do not receive *your* notification.

Each qualified beneficiary has separate and independent election rights. *You* or *your spouse* or *domestic partner* can elect coverage on behalf of any other qualified beneficiary.

In considering whether to elect continuation coverage, *you* and *your dependents* should take into account

that a failure to continue group health coverage will affect future rights under federal law. First, *you* and *your dependents* can lose the right to avoid having pre-existing exclusions applied by other group health plans if *you* or *your dependents* have more than a 63-day gap in health coverage, and election of continuation coverage may help to avoid such a gap. Second, *you* and *your dependents* will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if *you* do not get continuation coverage for the maximum time available to *you.* Finally, *you* and *your dependents* should take into account that *you* have special enrollment rights under federal law. *You* and *your dependents* have the right to request special enrollment in another group health plan for which *you* or *your dependent* are otherwise eligible (such as a plan sponsored by *your spouse*'s employer) within 30 days after *your* (or *your dependent)* group health coverage ends because of the qualifying events listed above. *You* and *your dependents* will also have the same special enrollment right at the end of continuation coverage if *you* elect continuation coverage for the maximum time available to *you.*

Maximum Period of Continuation Coverage

The maximum period of continuation coverage for an individual(s) who qualifies due to termination of employment, reduction in hours worked or change to ineligible status is 18 months from the date of the qualifying event.

The maximum period of continuation coverage for individuals whose coverage ended because of the death of the *employee*, divorce, termination of a *Domestic Partnership* or loss of eligibility by a covered *dependent* child is 36 months from the date of the qualifying event. In the event of *employer* bankruptcy, qualifying *retirees* and their *dependents* are entitled to continuation coverage for the life of the *retiree*. If the *retiree* is not living at the time of the bankruptcy, the *retiree's* surviving *spouse* or *domestic partner* is entitled to continuation coverage for life. However, if a *retiree* dies after bankruptcy, the surviving *spouse* or *domestic partner* and *dependent* children may elect only an additional 36 months of continuation coverage after the death.

If the initial qualifying event is a termination of employment, reduction of hours worked or change to ineligible status, the 18-month continuation period can be extended in any of the following three circumstances:

First, the maximum period of coverage for qualified beneficiaries other than the employee may be extended up to a total of 36 months due to the occurrence of one of the following second qualifying events prior to the end of the 18-month period: *employee's* death, entitlement to *Medicare* as described below, divorce or legal separation from a *spouse*, a termination of a *domestic partnership* or a child's loss of *dependent* status under the *plan.* These events are a second qualifying event only if they would have caused the qualified individual to lose coverage under the *plan* if the first qualifying event had not occurred. *You* or another qualified beneficiary must notify the *plan administrator* of these events within 60 days following the date coverage would have been lost if the second qualifying event were an initial qualifying event at the address provided in this booklet. The maximum period will be computed from the date of the

earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

Second, the *employee* is entitled to *Medicare* at the time of an initial qualifying event, then the period of continuation for other family members who are qualified beneficiaries is the later of 36 months from the date of *Medicare* entitlement, or 18 months from the date coverage would otherwise end due to the qualifying event.

Third, *you* or a *dependent*, as a qualified beneficiary, is disabled (for Social Security purposes as defined under Title II or XVI of the Social Security Act) at the time of the original qualifying event or before the 60th day of continued coverage, the 18-month period is extended up to 29 months for the individual with a disability and any other non-disabled family members who are also entitled to continuation coverage. A higher premium may be charged for the additional 11 months of coverage.

The disability extension applies only if *you* notify the *plan administrator* at the address in this booklet before the end of the initial 18-month continuation coverage period and within 60 days of the latest of (1) the Social Security Administration's determination of disability; (2) the date on which the initial qualifying event occurs; or (3) the date on which coverage under the *plan* would have otherwise been lost as a result of the initial qualifying event.

If *you or another qualified beneficiary* are receiving continuation coverage under a disability extension, *you* or another qualified beneficiary must notify the *plan administrator* at the address provided in this booklet within 60 days of any final determination from the Social Security Administration that the individual is no longer disabled. *Your* notice should include a copy of the final determination letter from the Social Security Administration.

Cost of Continuation Coverage

The cost of continuation coverage is determined by *your employer* and paid by the qualified beneficiary. If the qualified beneficiary is not disabled, the applicable premium cannot exceed 102% of the *plan's* cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the *plan's* cost of coverage.

You and any other qualified individual(s) must make the first payment within 45 days of notifying the *plan* of *your* election of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless *your employer* establishes a longer payment schedule. Rates and payment schedules are established by *your employer* and may change over time. *Qualified beneficiaries* will receive coupons to make payments once enrolled.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the required first payment within 45 days or any subsequent required payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Once a qualified beneficiary has elected COBRA, coverage ends on the earliest of the:

- Date the maximum continuation period expires;
- Date the qualified beneficiary becomes entitled to coverage under *Medicare* after making the COBRA election ;
- Last period for which payment was made when coverage is canceled due to nonpayment of the required cost;
- Date the *employer* no longer offers a group medical plan to any of its *employees*; or
- Date the qualified beneficiary becomes covered under any other group medical plan after making the COBRA election that does not exclude or limit coverage for a pre-existing condition the qualified beneficiary may have as provided under HIPAA.

Eligibility for Medicare, or enrollment in another group health plan, prior to making the COBRA election will not result in early termination of COBRA continuation coverage.

Continuation coverage may also terminate earlier than the maximum period under the following circumstances:

- If coverage was extended to 29 months because a qualified beneficiary was disabled and the Social Security Administration determines that the individual is no longer disabled, the continuation coverage will cease even if the full 29 months has not elapsed. However, continuation coverage will not end until the month that begins more than 30 days after the determination.
- For any cause, such as fraudulent claim submission, that would result in a termination of coverage for a similarly-situated non-COBRA beneficiary.

A qualified beneficiary will be notified if continuation coverage ends before its maximum period.

Your ERISA Rights

As a *covered person* in the Aurora Accountable Care Network *Plan you* and *your dependents* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all *covered persons* shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the *plan administrator's* office and at other specified locations, all documents governing the *plan*, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the *plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The *plan administrator* may make a reasonable charge for the copies.

Receive a summary of the *plan's* annual financial report. The *plan administrator* is required by law to furnish each *covered person* with a copy of this summary annual report.

Continue Group Medical Plan Coverage
Continue medical care coverage for *yourself*, *spouse* or *dependents* if there is a loss of coverage under the *plan* as a result of a qualifying event. *You* or *your dependents* may have to pay for such coverage. Review this summary plan description and the documents governing the *plan* on the rules governing *your* COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-Existing Conditions Under Your Group Medical Plan.
You and *your dependents* should be provided a certificate of creditable coverage, free of charge, from the *plan* insurance issuer when *you* lose coverage under the *plan*, when *you* become entitled to elect COBRA continuation coverage, when *your* COBRA continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage. Without evidence of creditable coverage, *you* may be subject to a pre-existing condition exclusion for up to 18 months after *your enrollment date* in *your* coverage under another plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for *covered persons* ERISA imposes duties upon the people who are responsible for the operation of the *employee* benefit plan. The people who operate *your* plan, called "fiduciaries" of the *plan*, have a duty to do so prudently and in the interest of *you* and other *covered persons* and beneficiaries. No one, including *your employer*, *your* union, or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA.

Enforce *Your* Rights
If *your* claim for benefits is denied or ignored, in whole or in part, *you* have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, if *you* request a copy of *plan* documents or the latest annual report from the *plan* and do not receive them within thirty (30) days, *you* may file suit in a Federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay *you* up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the *plan administrator*. If *you* have a claim for benefits, which is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court. In addition, if *you* disagree with the *plan's* decision or lack thereof concerning the status of a medical child support order, *you* may file suit in Federal court. If it should happen that plan fiduciaries misuse the *plan's* money, or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If *you* are successful the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your* claim is frivolous.

Assistance with *Your* Questions
If *you* have any questions about *your plan*, *you* should contact the *claims administrator*, UMR or MedImpact, as applicable. If they are unable to answer *your* questions, then *you* should contact the *plan administrator*. If *you* have any questions about this statement or about *your* rights under ERISA, or if *you* need assistance in obtaining documents from the *plan administrator*, *you* should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in *your* telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. *You* may also obtain certain publications about *your* rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administration

Plan Name
The formal name of the *plan* is the Aurora Health Care, Inc. Aurora Accountable Care Network.

Plan Sponsor
Aurora Health Care
3305 W. Forest Home Ave.
Milwaukee, WI 53215
(414) 647-3448

or

Aurora Health Care
P.O. Box 340200
Milwaukee, WI 53234-9930

Plan Identification
The corporate tax identification number (*Employer* Identification Number, or EIN) assigned by the Internal Revenue Service to the plan sponsor is 39-1442285.

Plan Number
503

Plan Administrator
Aurora Health Care
3305 W. Forest Home Ave.
Milwaukee, WI 53215
(414) 647-3448

Type of *Plan*
This is an *employee* welfare benefit *plan* that provides medical and *prescription drug* benefits.

Plan Funding
Health benefits are self-funded from accumulated assets and are provided directly from the general assets of the *plan sponsor*.

The amount of *employee* contributions required to participate in the *plan* is generally determined annually and communicated during the annual enrollment period.

Payments out of the *plan* to *health care providers* on behalf of the *covered person* will be based on the provisions of the *plan*.

Plan Year
The *plan year* is the 12-month fiscal period for Aurora Health Care beginning January 1 and ending December 31.

Agent for Service of Legal Process
Senior Vice President of Total Rewards
Aurora Health Care
3305 W. Forest Home Ave.
Milwaukee, WI 53215
(414) 647-3448

Claims Administrator
***Medical Claims (excluding prescription drugs*)**
UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541
1-800-860-5217

***Prescription Drug* Claims**
MedImpact Healthcare Systems, Inc.
10680 Treena Street, Stop 5
San Diego, CA 92131
1-800-788-2949

Collective Bargaining Agreement
Some *employees* under the *plan* participate in the *plan* pursuant to a collective bargaining agreement ("CBA"). A *covered person* who is under a CBA may obtain a copy of the applicable CBA by making a written request to the *plan administrator*. A *covered person* may also review a copy of the agreement at the *employer's*

human resource department or at another readily available location.

Definitions

The following terms define specific wording used in this *plan*. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this *plan*. Each of these terms has been listed in italics throughout this summary plan description.

Accident
An unforeseen and unavoidable event resulting in an *injury*.

Activities of Daily Living (ADL)
Routine self-care activities that people tend to do everyday. ADLs include eating, bathing, dressing, toileting, transferring (walking) and continence.

Ambulatory Surgical Facility
A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Amendment (Amend)
A formal document signed by the representatives of Aurora Health Care. The *amendment* adds, deletes or changes the provisions of the *plan* and applies to all *covered persons*, including those persons covered before the *amendment* becomes effective, unless otherwise specified in the *plan*.

Annual Out-of-Pocket Limit
The maximum amount the *covered person* pays for medical services, supplies and treatment incurred in a *benefit year*. If a *covered person* uses both an *in-network provider* and *out-of-network provider*, two separate *annual out-of-pocket limits* will apply. Once a *covered person* reaches his or her *annual out-of-pocket limit*, the cost for medical services, supplies and treatment during the rest of the *benefit year* is paid by the *plan*. The *annual out-of-pocket limit* includes the *deductible and co-insurance*, but not the amount by which benefits are reduced if a *covered person* uses an *out-of-network provider*.

Benefit Year or Year
The word *year*, as used by the *plan*, refers to the *benefit year*, which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums accumulate during the *benefit year*.

Birthing Center
A public or private facility, other than private offices or clinics of *physicians*, which meets the free-standing *birthing center* requirements of the State Department of Health in the state where the *covered person* receives the services.

The *birthing center* must provide: (1) a facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; (2) supervision of at least one specialist in obstetrics and gynecology; (3) a *physician* or certified *nurse* midwife at all births and immediate postpartum periods; (4) extended staff privileges to *physicians* who practice obstetrics and

gynecology in an area *hospital*; (5) at least two beds or two birthing rooms; (6) full-time nursing services directed by an R.N. or certified *nurse* midwife; (7) arrangements for diagnostic X-ray and lab services; and (8) the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must accept only patients with low-risk pregnancies, have a written agreement with a *hospital* for *emergency* transfers and maintain medical records on each patient and child.

Chiropractic Services
The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claims Administrator
The third party hired by Aurora Health Care to administer the benefits of the *plan*. Currently, the *claims administrators* are UMR and MedImpact Healthcare Systems, Inc. UMR and MedImpact perform claims processing and other specified administrative services in relation to the *plan*. The *claims administrator* is not an insurer of health benefits under this *plan*.

Co-insurance
Co-insurance is the portion of covered expenses paid by *you* and by the *plan*. The *co-insurance* applies only to the covered medical expenses that do not exceed the *usual and customary charge* or the *negotiated fee* for a provider in the AACN.

The *covered person* is responsible for paying his or her *co-insurance* directly to the *health care provider* at the time of service or when billed by the *health care provider*. *Co-insurance* is in the form of a percentage of covered charges.

Congenital Defect Surgery or Treatment
A *surgery or treatment* that provides functional repair or restoration of any defective body part when repair is necessary to achieve normal body function. The defect must have existed at birth. Psychiatric and/or emotional distress is not considered *a medically necessary* indication for congenital defect surgery/treatment. (Treatment of port wine stains and other hemangiomas of the head and neck are considered *medically necessary*.)

Cosmetic Surgery
A procedure or treatment performed primarily for psychological purposes or to preserve or improve appearance, rather than the repair or restoration of a body part that is needed to achieve normal body function, which is lost or impaired due to an illness or injury. Psychiatric and/or emotional distress is not considered a medically necessary indication for cosmetic procedures.

Covered Person
This means either the enrolled *employee* or an enrolled *dependent,* including a COBRA qualified beneficiary.

Custodial Care
Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Deductible
The amount the *covered person* pays for medical services, supplies and treatment received from providers in a

benefit year before the *plan* will pay any amount of *eligible expenses*. If a *covered person* uses both an in-network and an *out-of-network provider*, two separate *deductibles* will apply.

Dependent(s)
As defined on page 19 of the Eligibility and Participation section of this booklet.

Diagnostic Charge
The *usual and customary fee* for X-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Disabled/Disability
The inability to do each and every normal activity of a person of like age and gender in good health as a result of medically determinable physical or mental impairment.

Domestic Partner/Domestic Partnership
Person in a *spouse* like relationship with an *employee* of the same gender. The *employee* and *domestic partner* together must meet all of the requirements specified in the Aurora Health Care Domestic Partner Benefits Policy with regard to enrollment of a *domestic partner* and termination of benefits for a *domestic partner*. The Policy is available at *your* local human resources department or the on line administrative manual on iConnect.

Durable Medical Equipment
Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the *plan* if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Elective Hospital Admission
A non-emergency *hospital* admission, which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Eligible Expense
The *usual and customary fee*, or for *in-network providers*, the *negotiated fee*, for medical services, supplies and treatment incurred by a *covered person* while coverage is in effect, unless otherwise specified.

Emergency or Medical Emergency
A serious medical condition resulting from an *injury* or *illness* which arises suddenly and unexpectedly, requiring immediate medical care/treatment, and use of the most accessible *hospital* equipped to furnish care generally within 24 hours of the onset to avoid jeopardy to the life or serious impairment of the *covered person*.

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, conditions resulting from an *accident* for which *emergency* medical care is rendered and other acute conditions.

Employee
Any common law *employee* of the *employer*. The term "*employee*" excludes any person who is not classified by the *employer* on its payroll records as an *employee* for purposes of federal income tax withholding. This exclusion applies, but is not limited, to a person classified as an independent contractor, even if such classification is determined to be erroneous or is retroactively revised (such as by a governmental agency or court order). If a person who was excluded from the definition of *employee* is later

determined to have been misclassified, the person shall continue to be treated as a non-employee for all periods prior to the date the classification of the person is corrected for purposes of the *plan*.

Employer
Aurora Health Care and participating affiliates.

Enrollment Date
The earlier of the first day of coverage or, if there is a waiting period, the first day of the waiting period. For late enrollees, the *enrollment date* is the first day of coverage.

Experimental/Investigational
Experimental or investigational services are those treatments, procedures (including organ transplantation) drugs, biological products, or medical devices, which in the judgment of the Health Plan are experimental or investigational in nature.

Experimental or investigational means that the service is defined as:

I. Those where there is insufficient information to determine if the service is of proven benefit for a particular diagnosis or for treatment of a particular condition; or
II. Those not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or
III. Those not of proven safety for a person with a particular diagnosis or a particular condition (e.g., that which is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well being of a person with the particular diagnosis or in the particular condition).

Reliable evidence includes anything determined to be such by the plan administrator, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

Health Care Provider
A *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in this section of the booklet.

High Deductible Health Plan **(HDHP)**
A medical *plan* with higher deductibles than typical plans, and a maximum limit on the out-of-pocket expenses that you must pay for covered expenses.

Home Health Care Agency
A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one *physician* and one registered graduate *nurse* to supervise the services provided.

Home Hospice Care
A program, licensed and operated according to state law, which is approved by the attending *physician* to provide palliative, supportive and other related care in the home for a terminally ill *covered person*.

Hospice Facility
A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative,

supportive, and other related care for a *covered person* diagnosed as terminally ill.

The facility must have an interdisciplinary medical team consisting of at least one *physician*, one registered *nurse*, one social worker, one volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital
A public or private facility, licensed and operated according to the law, which provides care and treatment by *physicians* and *nurses* at the patient's expense of an *illness* or *injury* through medical, surgical and diagnostic facilities on its premises. A *hospital* does not include a facility or any part thereof, which is, other than by coincidence, a place for rest, the aged or convalescent care.

Illness
Any bodily sickness, disease or *mental/nervous disorder*. For purposes of this *plan*, pregnancy will be considered as any other *illness*.

Infertility
The documented inability to conceive after one *year* of unprotected sexual intercourse.

Injury
A condition that results independently of an *illness* and all other causes and is a result of an externally violent force or *accident*.

In-Network Provider
When used to describe a provider of medical services, supplies and treatment, means a *health care provider* as described in this section of the booklet who has entered into an agreement with Aurora Accountable Care Network (AACN) to provide medical services, supplies and treatment to *covered person*s under the *plan*.

Inpatient
Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit
A section, ward or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Lifetime
The period of time *you* or *your* eligible *dependent*(s) participates in this *plan* or any other *plan* sponsored by the *employer*.

Lifetime Benefit Maximum
With respect to a particular benefit, the maximum that will be paid by the *plan sponsor* for any combination of in-network or out-of-network benefits, provided to each *covered person* during the period of time in which the *covered person* is covered under the *plan* or any other plan sponsored by the *employer*.

Any amount *you* or *your* eligible *dependents* have accumulated toward a benefit maximum of any other previous medical *plan* sponsored by the employer will be counted toward the benefit maximum of this *plan*.

Maintenance Care/Therapy
Unless specifically mentioned otherwise in the *plan*, the *plan* does not provide benefits for medical services and supplies intended primarily to maintain a level of physical or mental function.

Therapy is considered maintenance if there is no reasonable expectation that services will provide significant measurable improvement in the patient's condition in a reasonable and generally predictable and finite period of time. This begins after the acute phase of an *illness* or *injury* has passed and the patient's recovery has reached a plateau or only minimal improvement can be demonstrated. AACN's Medical Management Team reviews medical records and therapy treatment plans to make a determination regarding maintenance therapy.

Medical Emergency – see Emergency.

Medically Necessary or Medical Necessity
Medical necessity means services and supplies appropriate in the treatment of the patient's diagnosed sickness, *injury*, condition or *illness*. To be considered *medically necessary*, the services or supplies must be:

- Consistent with the symptoms or diagnoses and the treatment of the patient's *injury* or sickness, condition or *illness*;
- Appropriate with regard to standards of good medical practice;
- Not solely for the convenience of a patient, *physician*, *hospital*, or ambulatory care facility;
- FDA-approved for the diagnosis;
- The most cost-effective alternative compared to other treatments with equivalent outcomes; and
- Have a net health outcome that is beneficial.

The intent of the *medical necessity* clause is to protect patients from irregular, dangerous, or unnecessary procedures. Because a *health care provider* has prescribed, ordered or recommended a treatment, service or supply does not, in itself, mean that it is *medically necessary* as defined above.

Medicare
Title XVIII (Health Insurance for the Aged or Disabled) of the United States Social Security Act as amended.

Mental/Nervous Disorder
For purposes of this *plan*, a *mental/nervous disorder* is any diagnosed medical condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in the "Medical Expenses Not Covered" section of this booklet, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

Mental/Nervous Treatment Facility
A public or private facility, licensed and operated according to the law, which provides: (1) a program for diagnosis, evaluation and effective treatment of *mental/nervous disorders*; and (2) professional nursing services provided by licensed practical *nurses* who are directed by a full-time R.N. The facility must have a *physician* on staff or on call.

The facility must also prepare and maintain a written plan of treatment for

each patient. The plan must be based on medical, psychological and social needs.

Morbid Obesity

A diagnosed medical condition in which the body mass index (BMI) is greater than 35.

Negotiated Fee
The fee agreed upon between AACN and a participating *physician*, *hospital*, pharmacy, or other *health care provider*, as the case may be, who is in the AACN .

Nurse
A person acting within the scope of her or his license and holding the degree of Registered Graduate *Nurse* (R.N.) or Licensed Practical *Nurse* (L.P.N.).

Obese
An adult who has a body mass index (BMI) of 30 or higher.

Oral Surgery
Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Out-of-Network Provider
When used to describe a provider of medical services, supplies or treatment, means a *health care provider* who has not entered into an agreement with Aurora Accountable Care Network (AACN) to provide medical services, supplies and treatment to *covered persons* under the *plan*. Without this agreement with AACN, the costs charged by an *out-of-network provider* may be greater than the costs for medical care benefits received in-network.

Outpatient
Treatment either outside of a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Physically or Mentally Disabled
The inability of a person to be self-sufficient as the result of a medical condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing medical condition.

Physician
A person acting within the scope of her or his license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan
Aurora Accountable Care Network.

Plan Administrator
The *plan administrator*, Aurora Health Care, is the named fiduciary of the *plan*, and exercises discretionary authority and control over the administration of the *plan* and the management and disposition of *plan* assets. The *plan administrator* shall have the discretionary authority to determine eligibility for plan benefits or to interpret and construe the terms of the *plan*.

The *plan administrator* may hire someone to perform claims processing and other specified services in relation to the *plan*.

Plan Sponsor
Aurora Health Care

The *plan sponsor* has the right to *amend*, modify or terminate the *plan* in any manner, at any time, regardless of

the health status of a person or beneficiary covered under the *plan*.

Plan Year
The 12-month fiscal period for Aurora Health Care beginning January 1 and ending December 31.

Practitioner
A *physician* or person acting within the scope of applicable state licensure/certification requirements and holding the degree of: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Optometry (O.P.T.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Certified *Nurse* Midwife (C.N.M.), Certified Registered *Nurse* Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy. D.), Psychiatrist (M.D., D.O.), Speech Therapist, Occupational Therapist, Certified Diabetic Educator, Certified Dietician, *Nurse Practitioner*, Physician Assistant, Advance Practice Nurse Prescriber (APNP), Licensed Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage or Family Therapists (LMFT), and Clinical Substance Abuse Counselor (SCAC, SAC)..

Prescription Drug
A legend drug or its generic equivalent, which has a *physician*'s written prescription order or refill, is dispensed by a licensed pharmacist and is approved for human use by the Food and Drug Administration.

Psychiatric Day Treatment Facility
A public or private facility, licensed and operated according to the law, which provides: (1) treatment for all its patients for not more than eight hours in any 24-hour period; (2) a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and (3) supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of *Hospitals*.

Reconstructive Surgery
Procedures performed to restore the function(s) of the body, which are lost or impaired due to an *injury* or *illness*. Psychiatric and/or emotional distress is not considered a medically necessary indication for reconstructive surgery.

Rehabilitation Facility
A legally operating institution or distinct part of an institution that has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *mental/nervous disorders*, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a *rehabilitation facility* for the treatment of mental/nervous medical conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility
A therapeutic sub-acute secure setting for adults or adolescents which provides residential care and treatment for chemical dependency. The facility must be accredited as a *residential treatment facility* by the Council on Accreditation or the Joint Commission on Accreditation of *Hospitals*.

Retiree
An *employee* who terminates employment with Aurora Health Care or an affiliated *employer* on or after age 55 with 10 or more years of vesting service in an Aurora Health Care sponsored retirement plan, and who meets the other requirements specified in this *plan*.

Second Surgical Opinion
Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility
A public or private facility, licensed and operated according to the law, which provides: (1) permanent and full-time facilities for 10 or more resident patients; (2) a registered *nurse* or *physician* on full-time duty in charge of patient care; (3) at least one registered *nurse* or licensed practical *nurse* on duty at all times; (4) a daily medical record for each patient; (5) transfer arrangements with a *hospital*; and (6) a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *illness* or *injury*, and is not, other than by coincidence, a rest home for *custodial care* or for the aged.

Specialized Treatment Facility
A *specialized treatment facility*, as the term relates to this *plan*, includes *birthing centers*, ambulatory surgical facilities, hospice facilities, skilled nursing facilities, mental/nervous treatment facilities, *substance abuse treatment facilities*, rehabilitation facilities, residential treatment facilities, psychiatric day treatment facilities and *substance abuse/chemical dependency day treatment facilities* as those terms are specifically listed in the "What the *Plan* Covers" section of this booklet.

Specialty Prescription Drug
Medications used to treat very specific medical conditions. A *Specialty Prescription Drug* typically is injectible, but certain oral medications are also classified as specialty. *Specialty Prescription Drugs* treat certain disease states that affect only a small percentage of the population. These medications also require close monitoring of the patient's clinical response, and a greater level of collaboration with the prescribing doctor. You can obtain a list of the drugs that are considered *Specialty Prescription Drugs* on iConnect > Employee Connection > Tell Me About > My Benefits > Plans for Your Health.

Spouse
The lawful *spouse* of the *employee,* as defined by the state law of the employee's primary residence.

Step Therapy
The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

Substance Use/Chemical Dependency Day Treatment Facility
A public or private facility, licensed and operated according to the law, which provides: (1) a program for diagnosis, evaluation and effective treatment of substance abuse; (2) detoxification services; and (3) professional nursing care provided by licensed practical *nurses* who are directed by a full-time R.N. The facility must have a *physician* on staff or on call. The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological and social needs.

Surgery
Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Surrogate Arrangement
A surrogate arrangement is one in which, pursuant to a contract or other understanding, a female agrees to become pregnant and relinquish the baby to another person or persons who intend to raise the child.

Third Surgical Opinion
Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of a *covered person* undergoing a surgical procedure.

Usual and Customary Fee (or Charge)
The fee most frequently charged to the majority of patients for the same service or procedure. The fee must be within the range of the fees most frequently charged in the same or similar medical service area for the service or procedure as billed by other *physicians* or *practitioners*.

Year
See "*Benefit Year*" on page 81.

You or Your
The *employee* who is eligible for coverage under the *plan.*

Additional Information

Future of the *Plan*

While Aurora anticipates that the *plan* described in this booklet will be continued, Aurora reserves the right to *amend*, modify, suspend contributions to, or discontinue this *plan* at any time. Should this occur, *you* will be notified of the changes.

Any expenses covered under the *plan* prior to the effective date of such amendment, modification, suspension or termination will be paid in accordance with the terms of the *plan* as then in effect.

Appendix A

Privacy Rights Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

The *plan* protects the privacy of *your* medical information. The *plan* will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the *plan sponsor*, Aurora Health Care, for *plan* administration purposes. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the *plan*, all capitalized terms herein have the definition given to them by the Privacy Regulations.

1. **Disclosure of PHI**
   a. Disclosures by *Plan*. The *plan* may disclose PHI to the following *employees* or classes of *employees* of the *plan sponsor* ("Authorized *Employee*s") to the extent necessary for the *plan sponsor* to perform *plan* administration functions that qualify as Payment or Health Care Operations:
      - Medical Management Staff
      - Credentialing Staff
      - Provider Affairs Staff
      - Employee Assistance Program Staff
      - Human Resource Staff
      - Teleservices Staff
      - Community-based Care Management Staff
      - Care Management Information Systems Staff
      - Care Management Staff
      - Enterprise Applications Information Services Staff
      - Chief Privacy Officer

   b. Disclosures by Business Associates. The *plan's* Business Associates may disclose PHI to the Authorized *Employee*s of the *plan sponsor* to the extent necessary for the *plan sponsor* to perform *plan* administration functions that qualify as Payment or Health Care Operations.

   c. Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the *plan* may disclose PHI to the Authorized *Employee*s of the *plan sponsor* to the extent necessary for the *plan sponsor* to perform the following *plan* administration functions:
      - The *plan's* Payment activities,
      - Those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the *plan*, and
      - All of the *plan's* Health Care Operations to the extent the *plan* and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

2. **Uses and Disclosures of PHI by the *Plan Sponsor.***
   The Authorized *Employee*s of the *Plan Sponsor* shall use and/or disclose PHI only to the extent necessary to perform *plan* administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

3. **Privacy Safeguards.**
   The Authorized *Employee*s of the *plan sponsor* agree to:

   a. Not use or further disclose PHI other than as permitted or required under the *plan* or as required by law;

   b. Ensure that any subcontractors or agents to whom the *plan sponsor* provides PHI agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to PHI;

   c. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

   d. Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

   e. Report to the *plan* any use or disclosure of PHI of which the *plan sponsor* becomes aware that is inconsistent with the uses or disclosures provided for in the *plan*;

   f. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the *plan's* privacy policies and procedures;

   g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the *plan's* privacy policies and procedures;

   h. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the *plan's* privacy policies and procedures;

   i. Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the *plan's* compliance with the Privacy Regulations;

   j. If feasible, return or destroy all PHI that the *plan sponsor* maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the *plan sponsor*. If return or destruction is not feasible, the *plan sponsor* agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

   k. Ensure that adequate separation between the *plan* and the *plan*

sponsor is established, as described below.

4. **Adequate Separation**.
   In accordance with HIPAA, only the Authorized *Employee*s may be given access to PHI, and such information will be used only for *plan* administration activities, not for employment-related activities.

5. **Limitations of PHI Access and Disclosure**.
   The Authorized *Employee*s may only have access to and use and disclose PHI for *plan* administration functions that the *plan sponsor* performs for the *plan* as described above.

6. **Noncompliance Issues**.
   If the Authorized *Employee*s do not comply with these privacy requirements, the *plan sponsor* shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Appendix B

Change In Status Mid-Year Enrollment Guidelines – Medical Plan Table of Contents

Personal Changes **Page**

Work Changes

Change In Status Mid-Year Enrollment Guidelines
Table of Contents

Work Changes (continued)

The following information is not part of the Medical Plan Document. This is administrative information only.

Important Note

Once elected, *your* coverage continues throughout the calendar *year*. The events listed in the Table of Contents may allow *you* to change *your* benefit coverage during the *year*. Otherwise coverage may only be changed during the open enrollment period for the following calendar *year*.

The IRS rules that govern mid-year changes in enrollment are strict and complex. Mid-year enrollment changes generally have to meet consistency requirements. The following chart is intended to provide *you* with general information about *your* coverage options for certain personal and work events that may change *your* benefit needs. However, the chart is not all inclusive, and individual circumstances may require somewhat different results.

Personal Changes

Event	Options	Coverage	*Employee* Action
1. You get married	**Enroll**: employee, *spouse* and/or *dependent* children In connection with the changes described above, you may also switch *plan* options.	**Elect:** single, employee + *spouse*, employee + child(ren), or family **Effective**: date of event. *Employee* may use Enrolled in Other Coverage to drop dependents or waive coverage.	**Documentation required:** Marriage certificate. Note: Two employees cannot double insure dependent(s).
2. You get divorced or legally separated	**Waive: cancel** *spouse* andspouse's *dependent*s who lose eligibility for coverage. In connection with the changes described above, you may also switch *plan* options.	**Effective:** date of event. If not elected within 60 days of event, employee continues premium payments through end of year. No claims honored after event. Employee may enroll in coverage under , Loss of Other Coverage if currently waived.	**Documentation required:** divorce decree or separation agreement.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Personal Changes - continued

Event	Options	Coverage	*Employee* Action
You enter into a same gender *domesticpartnership* **Note**: There may be imputed income tax implications for *domestic partner*/*dependent* coverage. Refer to Domestic Partner Tax Implications Notice..	**Enroll:** *domestic partner* and *domestic partner*'s eligible *dependent*(s) (only if *domestic partner* also has coverage under the *plan*). In connection with the change described above, you may also switch *plan* options.	**Elect:** employee + *spouse* or family coverage. **Effective:** date of event.	**Documentation required:** Affidavit of *Domestic Partnership*.
4. You end aSame Gender *domestic partnership*	**Waive:** cancel coverage for *domestic partner* and *domestic partner*'s covered *dependent*(s) In connection with the changes described above, you may also switch *plan* options.	**Effective:** date of event. If not elected within 60 days of event, employee continues premium payments through end of year. No claims honored after event. **NOTE:** *Employee* may enroll in coverage under Lloss of Other Coverage, if currently waived.	**Documentation required:** Affidavit of Termination of *Domestic Partnership*.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Personal Changes - continued

Event	Options	Coverage	*Employee* Action
5. You gain a *dependent* child - birth, adoption, legal guardianship, foster child, or a new *dependent* child of your *domestic partner* (same gender).	**Enroll:** new child, employee and/or other *dependent*s. Children of *domestic partners* can only be covered if *domestic partner* is also enrolled for coverage. In connection with the changes described above, you may also switch *plan* options.	**Elect:** single, employee + child(ren), or family coverage if not currently enrolled. **Effective:** date of event.	**Documentation required:** birth certificate or hospital provided documentation of birth,court documents proving placement for or final adoption. Legal guardianship/foster care requires court document stating date effective and who has primary responsibility for coverage. *Domestic partnership* enrollments require affidavit of *Domestic Partnership*.
6. You or your *dependent*s enroll in other coverage in plan outside of Aurora due to a mid year election event.	**Waive: cancel** coverage of *employee* and/or *dependent*s.	**Effective:** end of the pay period containing date of event.	**Documentation required:** documentation of other coverage showing start dates of all covered participants.
7a. You lose coverage for *employee* and/or *dependent*s under other plan **or** **7b. Incur a significant Reduction in coverage in another plan**	**Enroll:** *employee* and/or *dependent*s who had coverage in other plan. In connection with the change described above, you may also switch *plan* options.	**Elect:** single, *employee* + child(ren), *employee* + *spouse*, or family coverage. **Effective:** the day after the date of event.	**Documentation required:** proof of loss of coverage, or proof of a significant reduction of coverage, showing all covered participants and date coverage was ended .

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Personal Changes - continued

Event	Options	Coverage	*Employee* Action
9. Your child is no longer a *dependent* or your *domestic partner's* child is no longer a *dependent* (other than resulting from divorce or termination of *domestic partnership*)	**Waive:** drop *dependent* from medical plan.	**Elect:** decrease coverage consistent with change. **Effective:** *Dependent* dropped end of pay period containing date of event. If not elected within 60 days of event, employee continues premium payments through end of year. No claims honored after event.	**Documentation required:** Proof of cessation of dependent status, such as court order terminating guardianship or foster child relationship.
9You have a death in the family.	A. Death of *employee* with single coverage	**Effective:** coverage ends date of death.	**Documentation required:** Death certificate.
	B. *Death of Employee with covered dependents*	**Effective:** the end of the month following the month of death. **Elect:** COBRA coverage offered to *dependent*s.	**Documentation required:** Death certificate.
	C. Death of *employee*'s *dependent*(s) while covered under plan	**Elect:** single, *employee* + child(ren), *employee* + *spouse*, or family coverage. **Effective:** date of death	**Documentation required:** Death certificate
	D. Death of *employee*'s *spouse* or *domestic partner* while covered under plan	**Elect:** single or *employee* + child(ren) coverage. **Effective:** date of death	**Documentation required:** Death certificate.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes

Event	Options	Coverage	*Employee* Action
10 New *employee* hired as a regular *employee* assigned 40 or more hours a pay period.	**Enroll:** choose plan type for *employee* and eligible *dependent*s.	**Elect:** single, *employee* + child(ren), *employee* + *spouse*, or family coverage. **Effective** first of the month following hire date. (If hired on the 1st of the month, then coverage effective that day)	**Note:** This event requires *you* to enroll within 30 days of the event. Deduction effective first payperiod containing the first of the month.
12. Your benefit-eligibility status changes: **From**: temporary or student/intern **To**: regular *employee* assigned 40 or more hours a pay period **or** **From**: less than 40 assigned hours **To**: more than 40 assigned hours	**Enroll:** *employee* and eligible legal *dependent*s.	**Elect**: single, *employee* + child(ren), *employee* + *spouse*, or family coverage. . **Effective:** first of the month following date of event. (If event is on the first of the month, coverage is effective immediately.)	**Note:** This event requires *you* to enroll within 60 days of the event. Deduction effective first paydate of effective month.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes – continued

Event	Options	Coverage	*Employee* Action
13. Your benefit-eligibility status changes: **From:** regular *employee* assigned 40 or more hours a pay period **To**: a position assigned less than 40 hours **or** **To**: temporary status	**Coverage Ends.**	**Effective:** end of the pay period containing date of event.	COBRA offered unless coverage ended due to non-payment of premium.
1314. Your benefit-eligibility status changes: **From**: regular full-time benefit eligible *employee* **To**: regular part-time benefit eligible *employee*	**Continue:** coverage continues at higher part-time premium rate **or** **Waive**: Cancel *employee* and/or *dependent*s **or** **Cancel**: *dependent*s In connection with the change described above, you may also switch *plan* options to the lower cost option.	No change. **Effective**: end of the pay period containing event. **Elect**: decrease coverage to single, *employee* + child(ren) or *employee* + *spouse*. **Effective**: *dependent's* coverage terms at the end of the pay period containing event; new coverage level effective first day of pay period following date of event.	**Note:** employee will be charged for entire pay period's coverage.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes – continued

Event	Options	Coverage	*Employee* Action
15. Your benefit-eligibility status changes: **From**: regular part-time benefit-eligible *employee* **To**: part-time *employee* with decrease in assigned hours, that results in a premium increase.	**Continue:** coverage continues at higher part-time premium rates **Elect**: decrease coverage to single, *employee* + child(ren), *employee* + *spouse* **or** In connection with the change described above, you may also switch *plan* options to the lower cost option.	No change. **Effective**: end of the pay period containing event. **Elect**: decrease coverage to single, employee + child(ren) or employee + *spouse*. **Effective**: *dependent's*coverage terms at the end of the pay period containing event; new coverage level effective first day of pay period following date of event.	**Note:** employee will be charged for entire pay period's coverage

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

16. Your benefit-eligibility status changes: **From:** regular part-time benefit eligible *employee* **To**: regular part-time *employee* with increase in assigned hours that results in a premium decrease	**Continue:** coverage at lower part-time premium rates **or** **Enroll**: Legal *dependents* to current coverage. If no current coverage may add *employee* and eligible legal *dependents.* In connection with the changes described above, you may also switch *plan* options to the higher cost option.	No change. **Elect**: *employee* + child(ren), *employee* + *spouse*, or family coverage consistent with change **Effective**: date of event	

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes – continued

Event	Options	Coverage	*Employee* Action
17. Your benefit-eligibility status changes: **From**: regular part-time benefit-eligible *employee assigned at least 40 hours per pay period.* **To**: regular full-time *employee* .	**Continue:** coverage at lower full-time premium rates. **Or** **Enroll:** Add legal *dependents* to current coverage. If no current coverage, may add *employee, spouse* and/or eligible legal *dependents.* In connection with the changes described above, you may also switch *plan* options to the higher cost option.	**Elect:** single, *employee* + child(ren), *employee* + *spouse*, or family coverage consistent with change. **Effective:** date of event.	
17 FMLA and/or Paid Leave	**Default:** coverage continues **or** **Elect:** Waive or decrease coverage. Change must be done on paper form.	No change **Effective:** Coverage continues through end of pay period containing event, or end of pay period containing requested term date. (If paid FMLA, coverage continues, cannot waive or decrease coverage)	Shared premiums charged for up to 12 weeks. Premiums deducted from pay (if any); otherwise, employee is billed.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

18Unpaid Leave (non-FMLA **Personal/Educational Leave** **PEL**	**Continue:** coverage continues for first 12 weeks *After 12 weeks:* **Continue:** coverage at full premium rates **or** **Elect:** Waive or decrease coverage. Coverage must be done on paper form. Personal and education leaves are immediately billed at full premium.	No change. No change. **Effective:** end of the month of event	Shared premiums charged for up to 12 weeks. Premiums deducted from pay (if any); otherwise, *employee* is billed. After 12 weeks *employee* is billed for full premiums to continue coverage.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes – continued

Event	Options	Coverage	*Employee* Action
19Return from leave of absence	**Continue:** coverage in effect during leave **or** **Enroll:** in previous coverage within 60 days of return by completing enrollment form. Enrollment/change must be done on paper form.	No change. **Effective:** date of return from FMLA leave or first of the month following date of return from non-FMLA leave.	
20Layoff/Severance	**Continue:** Continues under COBRA at same cost. **or** **Waive:** waive coverage of *employee* and/or legal *dependent*s. Change must be done on paper form.	No change. **Effective:** End of pay period containing completion of cancellation form.	

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged prorated premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to = and then going to s Employee Connection.
- Dependent verification -- If you enroll any dependents, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.

Work Changes – continued

Event	Options	Coverage	*Employee* Action
21Open Enrollment	**Enroll:** change plan coverage (e.g., AACN1 or AACN2) and plan type coverage (e.g., single, *employee* + child(ren), *employee* + *spouse* or family) May add legal *dependent(s)* **Waive:** cancel *employee* and/or *dependent*(s)	**Elect:** single, *employee* + child(ren), *employee* + *spouse*, or family coverage. **Effective:** January 1st. **Effective:** December 31st. .	
24. You terminate employment	Coverage Ends**.**	**Effective:** Coverage continues through end of pay period containing event.	COBRA offered unless coverage ended due to non-payment of premium.
25. You retire	Coverage Ends.	**Effective:** coverage continues through end of pay period containing event	COBRA or *retiree* coverage offered if eligible unless coverage ended due to non-payment of premium. Note: Request retirement application 90 days prior to retirement.

NOTES:

- Timeframe – *you* must request any benefit changes within 60 days of event.
- Premiums – *you* will be charged premiums based on the effective date of your coverage change.
- If *you* have proof of other coverage it may waive the 12-month pre-existing clause.
- Please complete the online enrollment by logging on to iConnect and then going to the *Employee* Connection.
- *Dependent* verification -- If you enroll any *dependents*, you must provide verification documentation to your local human resources department.
- If you switch options other than during open enrollment, the deductible and out-of-pocket amounts do not carry over from the prior option to the new option.