THE COUNTY OF MILWAUKEE

HEALTH CARE

BENEFIT PLAN

PREFERRED PROVIDER PLAN COVERAGE

GENERAL INFORMATION ABOUT YOUR PLAN

Your comprehensive health care benefit plan is provided by The County of Milwaukee for its employees under the terms and conditions of the Group Master Plan Document on file with The County of Milwaukee.

All medical expenses covered under your health care benefit plan as described in this booklet are paid for by The County of Milwaukee. This Plan is administered by Wisconsin Physicians Service Insurance Corporation (WPS) under an agreement between The County of Milwaukee and WPS.

This booklet highlights the provisions of the Plan. Be sure to familiarize yourself with its contents, and keep it in a safe place where you can refer to it quickly when you need it.

This booklet explains how the Plan works: what it pays for, what is not covered, how to submit expenses and claim benefits. Every medical cost situation cannot be specifically described in this material. If you have specific questions pertaining to coverage, please contact:

WPS Administrative Services
1717 West Broadway
P.O. Box 8190
Madison, Wisconsin 53708

Phone: Please call the number shown on your Plan Identification Card
Website: www.wpsic.com

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OUTLINE OF BENEFITS

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Network	WPS Statewide/Beechstreet Wrap	Not Applicable
Annual Deductible Amount	$150 per member, not to exceed $450 per family	$400 per member, not to exceed $1,200 per family
Coinsurance	90% of charges Wherever the term “charges” is used in this outline, charges shall mean the negotiated rate determined by WPS that is paid to each preferred provider.	80% of charges Wherever the term “charges” is used in this outline, charges shall mean the usual, customary and reasonable amounts determined by WPS as reasonable as defined in the Plan under the definition of “charge.”
Lifetime Maximum Benefit Limit	Unlimited	
Dependent Coverage	Dependent - 19, Full-Time Student – 25	
Professional Services		
Surgical services	Deductible, then 90% of charges	Deductible, then 80% of charges
Physician office visits - office visit charge only	$20.00 copayment, then 100% of charges	$40.00 copayment, then 100% of charges
Maternity services	Deductible, then 90% of charges	Deductible, then 80% of charges
Diagnostic radiology and laboratory services provided in a physician’s office	Deductible, then 90% of charges	Deductible, then 80% of charges
Radiology, pathology and laboratory services provided and billed by an independent radiologist, pathologist or laboratory	Deductible, then 90% of charges	Preferred deductible, then 90% of charges
Anesthesia services provided and billed by an independent anesthesiologist	Deductible, then 90% of charges	Preferred deductible, then 90% of charges
Radiation therapy and chemotherapy	Deductible, then 90% of charges	Deductible, then 80% of charges
Oral surgical services - limited to those procedures specifically listed in the policy	Deductible, then 90% of charges	Deductible, then 80% of charges
Hospital Services - Does not apply to alcoholism, drug abuse and nervous or mental disorders		
Inpatient services Precertification required or a $100 penalty will be applied to the confinement	Deductible, then 90% of charges	Deductible, then 80% of charges
Outpatient miscellaneous hospital expenses	Deductible, then 90% of charges	Deductible, then 80% of charges

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Emergency room visit - facility fee only Copayment will be waived for that visit by us if you are admitted as a resident patient to the hospital directly from the hospital emergency room	$50.00 copayment, then 100% of charges	$50.00 copayment, then 100% of charges
Emergency room services provided during an emergency room visit	Deductible, then 90% of charges	Deductible, then 80% of charges
Physical, speech, occupational and respiratory therapy	Deductible, then 90% of charges	Deductible, then 80% of charges
Preventive Services		
Routine medical exams, including routine eye and hearing exams Members age 18 and older are limited to one physical exam, hearing exam and eye exam per calendar year.	100% of charges	Not Covered
Immunizations through age six	100% of charges	100% of charges
Immunizations over age six	100% of charges	Not Covered
Routine mammograms and pap smears	100% of charges	Deductible, then 80% of charges
Other Covered Health Care Services		
Physical, speech, occupational and respiratory therapy performed in an office setting	Deductible, then 90% of charges	Deductible, then 80% of charges
Emergency ambulance services	Deductible, then 90% of charges	Deductible, then 90% of charges
Prosthetic devices (other than dental prosthetics)	Deductible, then 90% of charges	Deductible, then 80% of charges
Casts, splints, strapping, orthopedic braces and crutches	Deductible, then 90% of charges	Deductible, then 80% of charges
Medical supplies	Deductible, then 90% of charges	Deductible, then 80% of charges
Durable medical equipment	Deductible, then 90% of charges	Deductible, then 80% of charges
Dental services: - dental repair of your sound natural teeth due to an injury provided treatment begins within one week and is completed within 90 days - extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease - sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease.	Deductible, then 90% of charges	Deductible, then 80% of charges

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Outpatient cardiac rehabilitation services	Deductible, then 90% of charges	Deductible, then 80% of charges
Home care - limited to 40 visits per calendar year (maximum is a combined maximum for preferred and all other providers)	Deductible, then 90% of charges	Deductible, then 80% of charges
Skilled nursing services in a licensed skilled nursing facility - limited to 120 days per confinement (maximum is a combined maximum for preferred and all other providers)	Deductible, then 90% of charges	Deductible, then 80% of charges
Kidney dialysis expenses	Deductible, then 90% of charges	Deductible, then 80% of charges
Diabetic supplies and equipment, other than insulin and disposable diabetic supplies	Deductible, then 90% of charges	Deductible, then 80% of charges
TMJ treatment - oral surgical services and non-surgical treatment - limited to $1,250 per member per calendar year (maximum is a combined maximum for preferred and all other providers)	Deductible, then 90% of charges	Deductible, then 80% of charges
Private duty nursing services	Deductible, then 90% of charges	Deductible, then 80% of charges
Certified nurse midwife services in a clinic or hospital, or other licensed facility	Deductible, then 90% of charges	Deductible, then 80% of charges
Orthotics prescribed by a physician	Deductible, then 90% of charges	Deductible, then 80% of charges
Artificial insemination (other than GIFT, in vivo or in vitro fertilization) - limited to three inseminations per menstrual cycle up to a maximum of 18 inseminations over any six month period.	Deductible, then 90% of charges	Deductible, then 80% of charges
Organ transplant procedures - limited to the procedures stated in the policy	Deductible, then 90% of charges	Preferred deductible, then 90% of charges, provided the facility is approved by us
Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders - Precertification by Health Management Center is Required **Preferred Providers are HMC Providers**		
Inpatient services - limited to 30 days per member per calendar year Precertification required or benefits are not payable	80% of charges	$50 deductible, then 50% of the amount that would have been paid if an HMC provider provided the service
Outpatient services Precertification required or benefits are not payable	95% of charges up to a maximum of 25 visits per member per calendar year	50% of the amount that would have been paid if an HMC provider provided the service up to a maximum of 15 visits per member per calendar year

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Transitional treatment arrangements - limited to 30 days per member per calendar year Precertification required or benefits are not payable	95% of charges	50% of the amount that would have been paid if an HMC provider provided the service
Co-Pay Prescription Legend Drugs		
Copayment	The following copayments apply when dispensed by a preferred pharmacy or through the mail order program: $5.00 for generic drugs, Prilosec OTC, Claritin and Claritin-D $20.00 for preferred brand-name drugs $40.00 for brand-name drugs $20.00 for diabetic supplies	
Oral contraceptives	Covered	
Prilosec OTC, Claritin and Claritin-D (written prescription required)	Covered	
Limitation	Retail - 30-day supply Mail Order - 90-day supply	
Mandatory generic and step therapy	Applicable	

This is only a summary of the benefits. For specific terms, provisions and conditions, please refer to this benefit booklet.

ELIGIBILITY AND COVERAGE

Eligibility

1. Eligible Employees.

Eligible employees are active employees who are appointed to a regular, temporary or emergency position with an assigned work week of 20 or more hours and who regularly works a uniform period of time in each pay period; and certain exempt positions pursuant to applicable County ordinances.

When husband and wife are both County employees, family coverage will be set up in only one employee's name. Should that person terminate his/her employment with the County, family coverage will be transferred onto the name of the spouse with no interruption of coverage provided a new application form is on file in the Department of Human Resources - Employee Benefits and Services Division within 30 days of the employee's termination of employment.

2. Eligible Dependents.

An eligible dependent is:

a. a covered employee's lawful spouse, excluding legally separated spouse;

b. a covered employee's unmarried natural child, adopted child, child placed for adoption with the covered employee, step-child or legal ward under age 19;

c. a covered employee's unmarried natural child, adopted child, child placed for adoption with the covered employee, step-child or legal ward under age 25, if he/she is a full-time student as determined by the Claim Administrator; and

d. an unmarried natural child of a dependent child (as described in b. above) until the dependent child is 18 years of age.

In the case of a child placed for adoption with the covered employee, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended.

If a dependent child becomes an eligible employee of the County, he/she is no longer eligible as a dependent and must make application as an eligible employee for coverage under the Plan.

A person is not an eligible dependent if he/she is:

a. covered under the Plan as a covered employee;

b. on active duty with the military service, including national guard or reserves, other than for duty of less than 30 days; or

c. in the case of a child:

(1) if such child provides 50% or more of his/her own support, as determined by the Claim Administrator;

(2) if such child is employed and eligible for other group health coverage through his/her employment.

No person shall be considered as an eligible dependent of more than one employee covered as a covered employee under the Plan.

A dependent child who is over the limiting age may remain covered as a dependent under the Plan if he/she meets certain requirements, provided the covered employee's family coverage remains in force under the Plan. The child must:

a. be unable to support himself/herself with a job because of mental retardation or physical handicap;

b. have become totally disabled before he/she reaches the limiting age; and

c. be principally supported by the covered employee.

Written proof of the child's totally disabling condition must be given to the Claim Administrator within 31 days of the child attaining the limiting age. Failure to provide such proof to the Claim Administrator within that 31-day period shall result in the termination of that dependent child's coverage in accordance with Section "Termination of Individual Coverage."

3. Eligible Retirees.

An eligible retiree is a person who:

a. is a covered employee who retires and who is eligible for a pension based on Milwaukee County Pension Ordinances;

b. is a former Milwaukee County employee prior to December 31, 1991 with 15 or more aggregate years of service who retires from current employment with United Regional Medical Services;

c. is a Milwaukee County school teacher who is eligible for pension benefits based on Milwaukee County Pension Ordinances;

d. is a dependent of a deceased active employee who qualifies for continued survivorship benefits based on Milwaukee County Pension Ordinances; and

e. the spouse of a deceased retiree who is eligible for on-going pension benefits based on Milwaukee County Pension Ordinances.

Enrollment Period

The enrollment period for an eligible employee is the period beginning immediately following an eligible employee's date of hire through the 31st day immediately following the end of his/her probationary period, if any. The enrollment period for an eligible dependent is the period beginning immediately following the dependent's eligibility date through the 31st day following the dependent's eligibility date.

Effective Date

1. New Entrants.

An eligible employee shall become covered under the Plan (eligibility date) on the first day of the calendar month following the processing period. An eligible dependent shall become covered under the Plan as of his/her eligibility date. In both cases, the employee must request single or family coverage under the Plan within 30 days after: (a) the employee's date of hire; or (b) the date the dependent becomes eligible, provided the employee has applied for family coverage under the Plan.

If the application is submitted to the Claim Administrator after his/her enrollment period ends, that employee and/or his/her dependents, if any, are late enrollees. Please see paragraph 2. below.

However, if an otherwise eligible employee is not actively at work with the Employer for any reason, other than for any health reason, on the date his/her coverage would otherwise become effective under the Plan, his/her single or family coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the Employer.

2. Late Enrollees.

A late enrollee (as defined in the Plan) may make written application to the Claim Administrator only during the annual enrollment period stated below. A late enrollee's effective date of coverage under the Plan will be January 1st following the annual enrollment period. Benefits are subject to any waiting periods for pre-existing conditions for late enrollees.

However, if an otherwise eligible employee is not actively at work with the Employer for any reason, other than for any health reason, on the date his/her coverage would otherwise become effective under the Plan, his/her single or family coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the Employer.

3. Change in Marital Status.

a. Changing From Single Coverage to Family Coverage Due to Marriage. If a covered employee has single coverage and wishes to change to family coverage to add an eligible spouse due to his/her marriage, the covered employee must apply for coverage within 30 days of the date of his/her marriage. The effective date of family coverage will be the first day of the calendar month following submission and acceptance of a completed application, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within 30 days of the date of marriage. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 30-day period ends, the eligible spouse is a late enrollee. Please see paragraph 2. above.

b. Applying For Coverage Due to Marriage. If an eligible employee wishes to apply for family coverage to add himself/herself and eligible dependent(s) due to his/her marriage, the eligible employee and/or eligible dependents must apply for coverage within 30 days of the date of marriage. The effective date of family coverage will be the first day of the calendar month following submission and acceptance of a completed application, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within 30 days of the date of marriage. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 30-day period ends, the eligible employee and his/her eligible dependents are late enrollees. Please see paragraph 2. above.

If the husband and wife are both County employees, family coverage will be set up in only one employee's name.

4. Adding a Newborn Natural Child.

a. Adding Newborn Natural Children to Existing Family Coverage. If a covered employee has family coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth. The covered employee should notify the Department of Human Resources - Employee Benefits and Services Division within 30 days of the child's birth.

b. Changing From Single Coverage to Family Coverage To Add a Newborn Natural Child. If a covered employee has single coverage, coverage is provided for his/her

newborn natural child from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. Prior to the end of that 60-day period, the covered employee must notify the Claim Administrator about the child's birth during that child's 60-day period. If the covered employee fails to notify the Claim Administrator, coverage for his/her newborn natural child shall terminate at the end of that child's 60-day period, unless the covered employee applies for family coverage as described below.

If a covered employee wishes to change to family coverage to add his/her newborn natural child, the covered employee should notify the Department of Human Resources - Employee Benefits and Services Division within 30 days of the child's birth. If the covered employee does not make such notification within 30 days, he/she must apply for coverage within the first 60 days after the birth of his/her natural child. The effective date for such family coverage will be the date of that child's birth as long as the application is on file in the Department of Human Resources - Employee Benefits and Services Division within that 60-day period of time. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 60-day period ends, his/her newborn natural child is a late enrollee. Please see paragraph 2. above.

c. Applying For Coverage Due to The Birth of a Newborn Child. If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the birth of his/her natural child, the eligible employee and/or his/her eligible dependents must apply for coverage within 30 days of the birth of the newborn natural child. The effective date of family coverage shall be the date of birth of the newborn natural child, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within that 30-day period. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 30-day period ends, the eligible employee and/or his/her eligible dependents are late enrollees. Please see paragraph 2. above.

5. Adding an Adopted Child.

a. Changing from Single to Family Coverage to Add a New Eligible Dependent Because of Adoption. If a covered employee has single coverage and wishes to change to family coverage to add a new eligible dependent because of his/her adoption of a child or a child placed for adoption, the covered employee should notify the Department of Human Resources - Employee Benefits and Services Division within 30 days of the child's adoption. If the covered employee does not make such notification within 30 days, he/she must apply for coverage within 60 days of the date of such adoption or placement for adoption. In the case of a child placed for adoption with a covered employee, the meaning of “placed for adoption” is defined in Section 632.896, Wisconsin Statutes, as amended. If the covered employee applies within that 60-day period, the effective date for such family coverage will be: (1) on the date a court makes a final order granting adoption of the child by the covered employee; or (2) on the date that the child is placed for adoption with the covered employee, whichever occurs first, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within that 60-day period. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 60-day period ends, his/her new dependent is a late enrollee. Please see paragraph 2. above.

If adoption of a child who is placed for adoption with the covered employee is not finalized, the child's coverage will terminate when the child's adoptive placement with the covered employee terminates.

b. Applying for Coverage Due to Adoption. If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the

adoption or placement for adoption of a child with the eligible employee, the eligible employee and/or his/her eligible dependents must apply for coverage within 30 days of the adoption or placement for adoption of the child. The effective date of family coverage shall be on the date a court makes a final order granting adoption of the child by the eligible employee or on the date that the child is placed for adoption with the eligible employee, whichever occurs first, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within that 30-day period. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 30-day period ends, the eligible employee and his/her eligible dependents are late enrollees. Please see paragraph 2. above.

6. Adding A Dependent Due To A Court Order.

If a court orders a covered employee with single or family coverage to provide coverage for health care expenses for his/her dependent child, that covered employee will be issued family coverage to include that child effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible for coverage under the Plan as determined by the Claim Administrator. Written application for that child's coverage must be made by either the covered employee, the child's other parent, the department, or the county child support agency under Section 59.53 (5), Wisconsin Statutes, as amended, using the Claim Administrator's application form. The completed form and a copy of the court order must be submitted to the Claim Administrator as soon as reasonably possible after the court order is issued to the covered employee. As long as the covered employee is eligible for family coverage under the Plan, that child's coverage will continue under the Plan until the date that court order is no longer in effect or the date that child has coverage under another group policy or individual policy that provides comparable health care coverage, as applicable, unless that child's coverage ends sooner in accordance with Section “Termination of Individual Coverage.” The covered employee must notify the Claim Administrator in writing about that court order ending and/or that other coverage becoming effective for that child as soon as reasonably possible after the covered employee becomes aware of that fact.

7. Addition of Dependents.

If a covered employee wishes to add any dependents under his/her family coverage who were not covered previously under the Plan (other than as described in paragraphs 3. through 6. above), such additional dependents will be covered under the Plan, provided the employee has applied for family coverage under the Plan and applies within 30 days of the dependent's eligibility date. The effective date of that eligible dependent’s coverage will be the first day of the calendar month following submission and acceptance of a completed application, as long as the application is made and is on file in the Department of Human Resources - Employee Benefits and Services Division within 30 days of the dependent’s eligibility date. If application is submitted to the Department of Human Resources - Employee Benefits and Services Division after that 30-day period ends, the eligible dependent is a late enrollee. Please see paragraph 2. above.

Annual Enrollment Period

A covered employee may apply for coverage as a late enrollee or change benefit plans during the annual enrollment period. The annual enrollment period occurs during the month specified by the Employer. Applications for benefit plan changes and coverage for late enrollees that are received during the annual enrollment period shall be effective the following January 1.

DEFINITIONS

The following definitions shall apply to this Plan:

Active Work / Actively at Work: when an employee is performing all of the full-time duties of his/her principal occupation in his/her job with the Employer for the required number of hours per week, and paid a reasonable wage, as determined by the Claim Administrator. These duties must be performed at the Employer's place of business, except to the extent that the employee must travel to perform his/her duties. The employee shall be deemed to be actively at work on: (1) each day of a paid vacation; or (2) a regularly-scheduled non-work day, provided that, in either case, he/she worked his/her entire last regularly-scheduled work day prior to such date.

Calendar Year: the period of time that starts with the participant's applicable effective date of coverage shown in the Claim Administrator's records, as determined by the Claim Administrator, and ends on December 31st of such year. Each following calendar year shall start on January 1st of that year and end on December 31st of that same year.

Certified Nurse Midwife: a person who is a registered nurse and is certified to practice as a nurse midwife by the American College of Nurse Midwives and by either the State of Wisconsin or by the state in which he/she practices.

Charge: an amount for a health care service directly provided to a participant by a health care provider that is reasonable, as determined by the Claim Administrator, when taking into consideration, among other factors (including national sources) determined by the Claim Administrator, amounts charged by health care providers for similar health care services when provided in the same geographical area. The term "area" means a county or other geographical area which the Claim Administrator determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount the Claim Administrator determines as reasonable may be less than the amount billed. Charges are incurred on the date the participant receives the health care service. Each preferred provider is paid at the negotiated rate determined by the Claim Administrator in accordance with the applicable contract between the Claim Administrator and that preferred provider. With respect to this paragraph, preferred provider does not include an independent radiologist, pathologist or anesthesiologist.

As required by Section Ins 3.60, Wis. Admin. Code, as amended, upon written or oral request from a participant for our charge for a health care service and if a participant provides us with the appropriate billing code that identifies the health care service (for example, CPT codes, ICD 9 codes or hospital revenue codes) and the health care provider's estimated fee for that health care service, we will provide you with any of the following:

1. a description of our specific methodology, including, but not limited to, the following:

- **a.** the source of the data used, such as our claims experience, an expert panel of health care providers, or other sources;
- **b.** the frequency of updating such data;
- **c.** the geographic area used;
- **d.** if applicable, the percentile used by us in determining the charge; and
- **e.** any supplemental information used by us in determining the charge.

2. The amount allowable by us under our guidelines for determination of the reasonable portion of the amount billed by the health care provider for a specific health care service provided to you in the

geographic area where you received the health care service. That may be in the form of a range of payments or maximum payment.

Benefits for charges for covered bilateral and multiple surgical procedures and for a covered surgical procedure that requires a surgical assistant or co-surgeon to be present are determined as described in the Plan.

In some cases the Claim Administrator may determine that the health care provider or its agent didn't use the appropriate billing code to identify the health care service provided to a participant. The Claim Administrator reserves the right to recodify and assign a different billing code to any health care service that the Claim Administrator has determined was not billed using the appropriate billing code.

Claim Administrator: WPS Administrative Services, a division of Wisconsin Physicians Service Insurance Corporation, acting as the health claim administrator under the terms of an Administrative Services Agreement with the Employer.

Complication of Pregnancy: a health condition needing medical treatment before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: medically necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia. Complication of pregnancy does not include: false labor; occasional spotting; rest prescribed during period of pregnancy; elective caesarean section.

Confinement/Confined: the period starting with a participant's admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with the participant's discharge from the same hospital or other facility. If the participant is transferred to another hospital or other facility for continued treatment of the same or related illness or injury, it's still just one confinement.

Copayment: that portion of the charge for a covered expense which a participant is required to pay to the health care provider for a certain health care service covered under the Plan. Copayments are a specific dollar amount.

Cosmetic Surgery: surgery performed to reshape normal structures of the body in order to improve either the patient's appearance or self-esteem.

Cosmetic Treatment: health care services used to improve either the patient's physical appearance or self-esteem.

Covered Employee: an eligible employee who meets all of the following requirements: (1) he/she is employed by the Employer; (2) he/she is eligible for coverage under the Plan; (3) he/she has properly enrolled; and (4) he/she is approved for coverage under the Plan. A covered employee shall include an eligible retiree.

Creditable Prior Coverage: any group coverage including: FEHP and Peace Corps, any group self-insured group health plans, governmental plans and church plans; individual health benefits coverage including short-term limited coverage, Medicaid, Medicare, Military-sponsored health care programs, Indian Health Service or tribal organization coverage, state high risk pool coverage, a public health plan or a flexible spending account which includes medical benefits (as defined in the Federal Regulations).

Custodial Care: health care services given to a participant if: (1) the participant does not require the technical skills of a registered nurse at all times; (2) the participant needs assistance for activities of daily living, including, but not limited to, dressing, bathing, eating, walking, taking medications or maintaining

continence; and (3) the health care services the participant requires are not likely to improve his/her physical and/or mental condition. Health care services may still be considered custodial care, as determined by the Claim Administrator, even if: (1) the participant is under the care of a physician; (2) the physician prescribes health care services to support and maintain the participant's physical and/or mental condition; or (3) health care services are being directly provided to the participant by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

Deductible: the amount of charges for covered expenses which a participant is required to pay to a health care provider for certain health care services covered under the Plan received from the health care providers in a calendar year before benefits are payable under the Plan.

Department: The State of Wisconsin Department of Health and Family Services.

Dependent: see paragraph 2. of subsection "Eligibility" for dependent eligibility.

Direction: verbal or written instructions, standing orders or protocols issued by a physician or health care provider.

Durable Medical Equipment: an item which can withstand repeated use and is, as determined by the Claim Administrator: (1) primarily used to serve a medical purpose with respect to an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) appropriate for use in a participant's home; (4) prescribed by a physician; and (5) medically necessary. All requirements of this definition must be satisfied before an item can be considered to be durable medical equipment.

Emergency Medical Care: a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;

2. serious impairment to the person's bodily functions; or

3. serious dysfunction of one or more of the person's body organs or parts.

Employee: see paragraph 1. of subsection "Eligibility" for employee eligibility.

Employer: Milwaukee County.

Experimental or **Investigative:** as determined by the Claim Administrator's Corporate Medical Director, the use of any health care services for a participant's illness or injury that, at the time it is used, meets one or more of the following:

1. requires approval that has not been granted by the appropriate federal or other government agency, such as, but not limited to, the federal Food and Drug Administration (FDA); or

2. isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or

3. is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, II or III clinical trial, except as required by law; or (d) an ongoing review by an Institutional Review Board (IRB); or

4. doesn't have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources the Claim Administrator determines to be authoritative.

Additional criteria that the Claim Administrator uses for determining whether a health care service is considered to be experimental or investigative and, therefore, not covered, for a particular illness or injury include, but are not limited to:

1. what are its failure rate and side effects;

2. whether other more conventional methods of treatment have been first exhausted;

3. whether it is medically necessary for the treatment of that illness or injury;

4. whether it is universally recognized as not experimental or investigative by Medicare, Medicaid and other third party payers (including insurers and self-funded plans); or

5. whether any documentation refers to the health care service as posing an uncertain outcome or having an unusual risk.

Investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, and drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis, are covered under the Plan to the extent described in the prescription legend drug benefits of the Plan.

To question whether a particular health care service is considered experimental or investigative, please see Section “Preauthorization Procedure.”

The determination of whether a health care service is experimental or investigative under the definition set out above and the Claim Administrator’s criteria shall be made by the Claim Administrator in its sole and absolute discretion. In any dispute arising as a result of the Claim Administrator’s determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of liability under the Plan or on any other basis shall be to provide Plan benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

Family Coverage: means coverage applies to a covered employee, his/her eligible spouse, and his/her eligible dependent children. To be covered, a dependent must be properly enrolled for coverage under the Plan. Family coverage also includes limited family coverage.

Full-Time Student: an eligible dependent who either: (1) attends the school for the number of credits, hours, or courses required by the school to be considered a full-time student; (2) attends two or more schools for credits towards a degree, which, when combined, equal full-time status at one of the schools; (3) participates in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. An eligible dependent continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a deficit in a participant’s ability to perform the basic activities of daily living (ADL’s), such as dressing, bathing, and eating or the instrumental activities of daily living such as using transportation, shopping or handling finances. The presence of a psychological condition alone will not entitle a participant to coverage for plastic or reconstructive surgery.

Health Care Provider: any person, institution or other entity licensed by the state in which he/she or it is located to provide health care services covered by the Plan to a participant, within the lawful scope of his/her or its license.

Health Care Services: treatment, services, procedures, drugs or medicines, devices, or supplies directly provided to a participant and covered under the Plan, except to the extent that such treatment, services, procedures, drugs or medicines, devices, or supplies are limited or excluded under the Plan.

Home Care: health care services directly provided to a participant in his/her home under a written home care plan. The attending physician must set up the home care plan. Such plan must be approved in writing by that physician. He/she must review it at least every two months; but this can be less frequent if he/she decides longer intervals are enough and the Claim Administrator agrees.

Hospice Care: health care services provided to a participant whose life expectancy, as certified by a physician, is six consecutive months or less, and which are provided by a licensed hospice care provider approved by the Claim Administrator. The care must be available on an intermittent basis with on-call health care services available on a 24-hour basis. Such care shall include health care services provided to ease pain and make the participant as comfortable as possible.

Hospital: an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by the Claim Administrator and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A hospital does not include, as determined by the Claim Administrator: (1) a convalescent or extended care facility unit within or affiliated with the hospital; (2) a clinic; (3) a nursing, rest or convalescent home or extended care facility; (4) an institution operated mainly for care of the aged or for treatment of mental disease, drug addiction or alcoholism; (5) sub-acute care center; or (6) a health resort, spa or sanitarium.

Illness: a physical illness, alcoholism, drug abuse, or a nervous or mental disorder.

Immediate Family: a covered employee's spouse, natural and adopted children, parents, grandparents, brothers, and sisters, and the spouses of such persons.

Incidental: associated services or items which are integral to the performance of another service or item, or which does not add significant time or effort to the other service or item.

Infertility: the physical inability to conceive after at least 12 consecutive months of unprotected sexual intercourse, and such inability is documented by a health care provider.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to a participant's teeth is not considered an injury.

Late Enrollee: an eligible employee, or dependent of an eligible employee, who does not request coverage under the Plan during an enrollment period during which the person is entitled to enroll for coverage under the Plan and who subsequently requests coverage under the Plan.

A late enrollee does not include:

1. a person who:

a. was covered under creditable prior coverage at the time the person was eligible to enroll; and

b. states, at the time of the initial eligibility, that coverage under another health benefit plan was the reason for declining enrollment; and

c. has lost coverage under creditable prior coverage, either voluntarily or involuntarily; and

d. requests enrollment within 30 days after the voluntary or involuntary loss of his/her creditable prior coverage; or

2. a person who is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period; or

3. a person who a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made.

Licensed Skilled Nursing Facility: a nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These services must be provided under professional direction and medical supervision as needed.

Limited Family Coverage: means coverage applies to a covered employee and his/her eligible spouse or coverage applies to a covered employee and his/her eligible dependent children. To be covered, a dependent must be properly enrolled and approved for coverage under the Plan.

Low-Dose Mammography: the x-ray examination of a breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maintenance Care: health care services provided to a patient after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

Maternity Services: professional services for prenatal and postnatal care. This includes: laboratory procedures; delivery of the newborn; cesarean and porro-cesarean sections; and care for miscarriages.

Medicaid/Medical Assistance: benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

Medically Necessary: a health care service directly provided to a participant by a hospital, physician or other health care provider that is required to identify or treat the participant's illness or injury and which is, as determined by the Claim Administrator: (1) consistent with the symptom(s) or diagnosis and treatment of his/her illness or injury; (2) furnished for an appropriate duration and frequency in accordance with accepted medical practice to treat that illness or injury; (3) not solely for the participant's convenience or the convenience of the physician, hospital or other health care provider; (4) the most appropriate health care service or location for providing such health care service, which can be safely provided to the participant and accomplishes the desired end result in the most economical manner; and (5) supported by information contained in the participant's medical records or from other relevant sources.

Medical Services: professional services recognized by a physician in the treatment of illness or injury and directly provided to a participant. Not included are: maternity services; surgery; anesthesiology; pathology; and radiology.

Medical Supplies: items which are, as determined by the Claim Administrator: (1) used primarily to treat an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) the most appropriate item which can be safely provided to a participant and accomplishes the desired end result in

the most economical manner; and (4) prescribed by a physician. The item's primary function must not be for the patient's comfort or convenience.

Medicare: benefits available under Title XVIII of the Social Security Act of 1965, as amended.

Miscellaneous Hospital Expense: the charges for regular hospital expenses (but not room and board, nursing services, and ambulance services) covered under the Plan for treatment of an illness or injury requiring either inpatient hospitalization or outpatient health care services at a hospital. For outpatient health care services, this includes charges for use of the hospital's emergency room and for emergency medical care provided to a participant at the hospital. Miscellaneous hospital expenses include take-home drugs.

Morbid Obesity/Morbidly Obese: when a participant's Body Mass Index (BMI) is 40 or above. Body Mass Index is defined as the participant's weight in kilograms divided by the square of their height in meters. A physician must define morbid obesity utilizing the method stated in this definition.

New Entrant: an eligible employee, or dependent of an eligible employee, who:

1. becomes part of the employer group after the commencement of the employer's initial enrollment period under the Plan. A new entrant must enroll for coverage under the Plan within 30 days immediately following his/her date of hire;

2. is a spouse or dependent child who a court orders be covered under the Plan and who requests enrollment under the Plan;

3. failed to request coverage under the Plan during an enrollment period, during which the person was entitled to enroll under the Plan, if the person:

a. was covered under creditable prior coverage at the time of the initial enrollment period; and

b. loses his/her creditable prior coverage, either voluntarily or involuntarily; and

c. requests enrollment under the Plan within 30 days immediately following the voluntary or involuntary loss of his/her creditable prior coverage; and

d. states, at the time of the initial eligibility, that coverage under another health benefit plan was the reason for declining enrollment; or

4. a person who is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period.

Nurse Practitioner: an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following: (1) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; (2) holds a master's degree in nursing from an accredited school of nursing; (3) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or (4) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (c) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Outpatient Treatment Facility: a facility licensed or approved by the Department. Its outpatient services must meet the Department's standards. It must provide the following outpatient services to prevent and treat an illness: (1) comprehensive diagnostic and evaluation services; (2) outpatient care and treatment, precare, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and (3) professional consultation.

Pap Smear: an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer.

Participant: a covered employee or any of his/her dependents who has been enrolled and approved for coverage under the Plan.

Physical Illness: a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

Physician: a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides health care services while he/she is acting within the lawful scope of his/her license. A physician is limited to the following:

1. Doctor of Medicine (M.D.);

2. Doctor of Osteopathy (D.O.);

3. Doctor of Dental Surgery (D.D.S.);

4. Doctor of Dental Medicine (D.D.M.);

5. Doctor of Surgical Chiropody (D.S.C.);

6. Doctor of Podiatric Medicine (D.P.M.);

7. Doctor of Optometry (O.D.); and

8. Doctor of Chiropractic (D.C.).

When required by law to cover the health care services of any other licensed medical professional under the Plan, a physician also includes such other licensed medical professional who: (1) is licensed by the state in which he/she is located; (2) is acting within the lawful scope of his/her license; and (3) provides a health care service which the Claim Administrator determines is a covered expense under the Plan.

Preferred Health Care Provider: a health care provider, other than a preferred physician or a preferred hospital, which has entered into a written preferred provider agreement with the health care provider network shown on a participant's Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com or by request from the Claim Administrator. Please note that preferred providers may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time that a participant receives any service from that provider. The participant may be required to pay a larger portion of the cost of his/her covered health care service if he/she sees any health care provider who is not a preferred provider at the time he/she receives the health care service.

Preferred Hospital: a hospital which has entered into a written preferred provider agreement with the health care provider network shown on a participant's Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com or by request from the Claim Administrator. Please note that

preferred providers may change periodically. While the on-line Preferred Provider Director is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time a participant receives any service from that provider. The participant may be required to pay a larger portion of the cost of his/her covered hospital services if he/she receives hospital services from any hospital that is not a preferred hospital.

Preferred Physician: a physician who has entered into a written preferred provider agreement with the health care provider network shown on a participant's Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com or by request from the Claim Administrator. Please note that preferred providers may change periodically. While the on-line Preferred Provider Director is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time a participant receives any service from that provider. The participant may be required to pay a larger portion of the cost of his/her covered hospital services if he/she receives hospital services from any hospital that is not a preferred hospital at the time he/she receives those hospital services.

Preferred Provider: a preferred hospital; a preferred physician; or a preferred health care provider. The term "preferred provider" when used in the benefit sections shall include an independent radiologist, pathologist and anesthesiologist who bills a participant directly for health care services.

Professional Services: services directly provided to a participant by a physician of the participant's choice to treat his/her illness or injury. Such services also include services provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising physician or the facility where the service is provided.

Reconstructive Surgery: surgery performed on abnormal structures of the body, caused by congenital defects, development abnormalities, trauma, infection, tumors or disease.

Retiree: see paragraph 3. of subsection "Eligibility" for retiree eligibility.

Services: hospital services, professional services, surgical services, maternity services, medical services or any other service directly provided to a participant by a health care provider, as determined by the Claim Administrator.

Single Coverage: means coverage applies only to a covered employee. To be covered, a covered employee must be properly enrolled and approved for coverage under the Plan.

Skilled Nursing Care: health care services furnished on a physician's orders which requires the skills of professional personnel such as a registered nurse or a licensed practical nurse and is provided either directly by or under the direct supervision of such professional personnel.

Sound Natural Teeth: teeth that: (1) are organic and formed by the natural development of the human body; (2) are not manufactured; (3) have not been extensively restored; (4) have not become extensively decayed or involved in periodontal disease; and (5) are not more susceptible to injury than whole natural teeth.

Supplies: medical supplies, durable medical equipment or other supplies directly provided to a participant by a health care provider, as determined by the Claim Administrator.

Supportive Care: supportive care is health care services provided to a participant whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

Surgical Services: an operative procedure performed by a physician and that is recognized by the Claim Administrator for the treatment of an illness or injury. Such services include sterilization procedures, preoperative and postoperative care. Such services don't include the reversal of a sterilization procedure, oral surgical services and maternity services.

Totally Disabled/Total Disability: this means the covered employee is unable due to illness or injury to perform the essential functions of any full-time job with the Employer, as determined by the Claim Administrator. A covered employee is not totally disabled if he/she is working on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself. For dependents and retired employees, this means the person's inability due to illness or injury to carry on most of the normal activities of a person of the same age and sex, including, but not limited to, being unable to work on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself, as determined by the Claim Administrator. The totally disabled person must be under the regular care of a physician. The Claim Administrator has the right to examine such person, including having health care providers examine that person, as often as the Claim Administrator reasonably requires to determine whether or not that person is totally disabled.

Transplant Preferred Provider: the hospital and/or physicians listed in the most recent Directory of Transplant Preferred Providers furnished to a covered employee in his/her Member Guide. Please note that transplant preferred providers may change periodically. While the directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time that a participant receives any service from that provider.

Treatment: management and care directly provided to a participant by a physician or other health care provider for the diagnosis, remedy, therapy, combating, or the combination thereof, of an illness or injury, as determined by the Claim Administrator.

Plan Coverage

Annual Deductible Amount

1. Annual Deductible Amount for Health Care Services Directly Provided to a Participant by a Preferred Provider.

The annual deductible amount is $150 per participant, not to exceed $450 per family. The annual deductible amount applies each calendar year. Charges for covered expenses for health care services directly provided to a participant by a preferred provider must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. No benefits are payable for the charges used to satisfy a participant's deductible amount. The participant is responsible for paying the charges used to satisfy the appropriate deductible amount. Charges for covered expenses for health care services applied by the Claim Administrator to satisfy the annual deductible amount stated in paragraph 2. will also be used to satisfy this annual deductible amount.

2. Annual Deductible Amount for Health Care Services Directly Provided to a Participant by a Health Care Provider Other than a Preferred Provider.

The annual deductible amount is $400 per participant, not to exceed $1,200 per family. The annual deductible amount applies each calendar year. Charges for covered expenses for health care services directly provided to a participant by a health care provider other than a preferred provider must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. No benefits are payable for the charges used to satisfy a participant's deductible amount. The participant is responsible for paying the charges used to satisfy the

appropriate deductible amount. Charges for covered expenses for health care services applied by the Claim Administrator to satisfy the annual deductible amount stated in paragraph 1. will also be used to satisfy this annual deductible amount.

When two or more members in one family incur charges due to the same accident, only one deductible per calendar year will be applied to the total of all charges incurred as a result of that accident.

Home and Office visit Copayment

The home and office visit copayment amount is $20.00 for preferred providers and $40.00 for health care providers other than preferred providers. An office visit is defined as being a participant's meeting with a physician or other health care provider at the physician's office, a medical clinic, an ambulatory surgical center, an urgent care center, immediate care center, skilled nursing facility or the outpatient department of a hospital, other than a hospital's emergency room. A home visit is defined as being a participant's meeting with a physician or other health care provider when billed by a physician in the participant's home. During that meeting the participant must receive from the physician or other health care provider: (1) medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology); or (2) manipulations by a physician, other than services related to physical therapy.

The copayment amount applies to the physician's charge for each home visit and office visit by a physician or other health care provider with a participant. The copayment does not apply to charges billed by a facility (for example, a hospital) for an office visit. Those charges shall be subject to the applicable annual deductible amount and coinsurance of the Plan.

For each participant, charges for covered expenses described in (1) and (2) above must add up to the copayment amount before benefits are payable for charges for the covered expenses for the physician's services stated in (1) and (2) above. No benefits are payable for the charges used to satisfy a participant's copayment amount. The participant is responsible for paying the charges used to satisfy the appropriate copayment amount.

Hospital Emergency Room Visit Copayment

The copayment amount for a participant's use of a hospital emergency room is $50.00. The copayment amount applies to each participant for each visit to the hospital emergency room. For each participant, charges for covered expenses must add up to the copayment amount before benefits are payable for charges for the emergency room fee billed by the hospital for use of the hospital emergency room (not including physician charges or miscellaneous hospital expenses). No benefits are payable for the charges used to satisfy a participant's copayment amount. The participant is responsible for paying the charges used to satisfy the appropriate copayment amount. The hospital emergency room copayment will be waived for that visit if a participant is admitted as a resident patient to the hospital directly from the hospital emergency room.

Coinsurance

1. Coinsurance for Health Care Services Directly Provided to a Participant by a Preferred Provider.

After the deductible amount stated above is satisfied, benefits are payable at 90% of the charges for the covered expenses for health care services directly provided to a participant by a preferred provider, unless specifically stated otherwise in the Plan, up to the annual out-of-pocket limit stated below.

2. Coinsurance for Health Care Services Directly Provided to a Participant by a Health Care Provider Other Than a Preferred Provider.

After the deductible amount stated above is satisfied, benefits are payable at 80% of the charges for the covered expenses for health care services directly provided to a participant by a health care provider other than a preferred provider, unless specifically stated otherwise in the Plan, up to the annual out-of-pocket limit stated below.

3. Coinsurance for Home and Office Visits.

After the home and office visit copayment amount shown above is satisfied, benefits are payable at 100% of the charges for: (a) medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology); or (b) manipulations by a physician, other than services related to physical therapy.

4. Coinsurance for Hospital Emergency Room Visits Error! Bookmark not defined.**.**

After the emergency room copayment amount shown above is satisfied, benefits are payable at 100% of the charges for the emergency room fee billed by the hospital for use of the hospital emergency room. This does not include a physician's professional services and miscellaneous hospital expenses for health care services provided during the visit to the hospital emergency room.

Annual Out-of-Pocket Limit

1. Annual Out-of-Pocket Limit for Health Care Services Directly Provided To You by a Preferred Provider.

The annual out-of-pocket limit for covered expenses for health care services directly provided to a participant by a health care provider other than a preferred provider is $1,500 per participant, not to exceed $2,500 per family. This total is made up of the annual deductible amount which a participant pays for covered expenses for health care services directly provided to him/her by a health care provider other than a preferred provider in one calendar year. Charges for covered expenses for health care services applied by the Claim Administrator to satisfy the annual out-of-pocket limit stated in paragraph 2. will also be used to satisfy this annual out-of-pocket limit.

2. Annual Out-of-Pocket Limit for Health Care Services Directly Provided To You by a Health Care Provider Other Than a Preferred Provider.

The annual out-of-pocket limit for covered expenses for health care services directly provided to a participant by a health care provider other than a preferred provider is $3,000 per participant, not to exceed $5,000 per family. This total is made up of the annual deductible amount and coinsurance amounts which a participant pays for covered expenses for health care services directly provided to him/her by a health care provider other than a preferred provider in one calendar year. Charges for covered expenses for health care services applied by the Claim Administrator to satisfy the annual out-of-pocket limit stated in paragraph 1. will also be used to satisfy this annual out-of-pocket limit.

The annual out-of-pocket limits stated in 1. and 2. do not include: (1) the coinsurance amounts for covered expenses for the treatment of alcoholism, drug abuse and nervous or mental disorders; (2) any reductions in benefits otherwise payable for failure to comply with preadmission and continued stay certification requirements shown in Section “Cost Containment”; (3) any copayment amounts, if applicable; and (4) any portion of the amount billed for a health care service which exceeds the Claim Administrator’s determination of the charge for such health care service.

No benefits are payable for charges used to satisfy the annual out-of-pocket limit, including a participant's annual deductible amount, coinsurance and copayment amounts. The participant is responsible for paying the charges used to satisfy the appropriate deductible, coinsurance and copayment amounts.

After the applicable annual out-of-pocket limit is reached, benefits are payable at 100% of the charges for covered expenses, unless specifically stated otherwise in the Plan, incurred by the participant during the remainder of the calendar year, subject to the lifetime maximum benefit limit and all other limitations, terms, conditions and provisions of the Plan.

Payment of Benefits

Subject to the annual deductible and copayment amounts shown above, benefits are payable as stated in subsection "Coinsurance" and "Annual Out-of-Pocket Limit" for charges for covered expenses a participant incurs in connection with a covered illness or injury, subject to all the provisions of the Plan. Covered expenses must be incurred while a participant is covered under the Plan. The deductible must be satisfied for the calendar year in which the covered expenses are incurred before benefits are payable, unless specifically stated otherwise in the Plan.

Benefits are payable for charges for covered expenses as described in this section. Any amount, fee or other expense which exceeds the Claim Administrator's determination of the charge for a health care service is the participant's sole responsibility to pay. The participant is also solely responsible to pay for all health care services or other services not covered under the Plan.

Benefits for charges for covered confinements are subject to: (1) preadmission and continued stay certification requirements shown in Section "Cost Containment"; and (2) the reductions in benefits shown in Section "Cost Containment" for failure to comply with the certification requirements. Please see Section "Cost Containment".

Covered Expenses

The following health care services are covered expenses. All health care services must be medically necessary. All health care services must be ordered by a physician because of a covered illness or injury. If the health care service is not listed in this subsection, that health care service is not covered and benefits are not payable under the Plan. Benefits are not payable for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see "Section General Exclusions".

1. Professional Services.

Benefits are payable for charges for the following professional services. This paragraph 1. does not include services for the treatment of mental health disorders, chemical dependency and substance abuse (please see subsection "Treatment of Mental Disorders, Chemical Dependency and Substance Abuse") and for organ transplants (please see paragraph 8. of this subsection).

a. Surgical services, other than oral surgical services, wherever performed.

Benefits are payable for surgical services for morbid obesity, including gastroplasty and gastric bypass surgery. Benefits are payable only if:

(1) prior authorization is received from the Claim Administrator; and

(2) a participant suffers from morbid obesity defined as a body mass index of greater than or equal to 40 **and** one of the following: (a) hypertension (diastolic greater than 100 consistently; (b) hyperlipidemia (cholesterol greater than 300; (c)

diabetes requiring medication; or (d) joint pain with degenerative changes of joint(s) as evidenced by x-ray;

(3) in the last 24 months, there has been a consistent program that is physician supervised with integrated components of a dietary regimen, appropriate exercise and behavioral modification and support;

(4) there has been a full trial of a lipase inhibitor (such as orlistat) or other medication recommended;

(5) an evaluation has been performed by a multi-disciplinary team with medical, surgical, psychiatric and nutritional expertise;

(6) there has been no previous bariatric surgery performed; and

(7) the surgery would be performed by a surgeon substantially experienced with appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment.

Benefits are limited to one bariatric procedure for the lifetime of a member while the member is covered under the policy. Benefits are not payable for the following surgeries: (1) biliopancreatic bypass; (2) jejunoileal bypass; (3) ileal bypass; and (4) gastric balloon.

Benefits are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by the Claim Administrator, only as follows. If the Claim Administrator determines benefits are payable for the services directly provided to a participant by a surgical assistant: (1) benefits for the covered services of a physician surgical assistant will be paid up to a maximum of 25% of the charge the Claim Administrator determines for that surgical procedure performed by the physician; and (2) benefits for the covered services of a surgical assistant who is not a physician will be paid up to a maximum of 10% of the charge the Claim Administrator determines for that surgical procedure performed by the physician.

Benefits payable for covered bilateral surgical procedures done at the same setting are limited to a maximum of one and one-half times the charge the Claim Administrator determines for the single surgical procedure. No additional benefits are payable for those procedures. A bilateral surgical procedure is the same surgical or invasive medical procedure performed on similar anatomical parts which are on opposite sides of a body which are usually identified as either right or left (e.g. eyes, ears, arms, legs, hands, feet, breasts, lungs or kidneys).

Benefits payable for covered multiple surgical procedures, other than bilateral surgical procedures, are limited to a maximum of 100% of the charge the Claim Administrator determines for the primary surgical procedure and 50% of the charge the Claim Administrator determines for each additional procedure, other than procedures determined to be incidental or inclusive. A primary surgical procedure is the surgical procedure with the highest charge as determined by the Claim Administrator . Multiple surgical procedures are more than one surgical or invasive medical procedure performed at the same setting, usually within the same related anatomical region, or same incisional area.

Benefits are not payable for incidental or inclusive surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental or inclusive surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest charge as determined by the Claim Administrator and which, in its opinion, are not clearly identified and/or do not add significant time or complexity to the surgical session.

Benefits payable for incidental surgical procedures are limited to the charge for the primary surgical procedure with the highest charge, as determined by the Claim Administrator. No additional benefits are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., benefits are payable for the hysterectomy, but not for the removal of the appendix).

b. Medical services for a physical illness or injury, including second opinions. Services must be provided: (1) in a hospital; (2) in a physician's office; (3) in an urgent care center; (4) in a surgical care center; or (5) in a participant's home. These services do not include home care services covered under paragraph 6. of this subsection.

c. Anesthesia services related to injury, surgical or maternity services which are covered under the Plan.

d. Maternity services. Maternity services are: (1) prenatal and postnatal care; (2) laboratory procedures; (3) delivery of the natural newborn child; (4) cesarean sections; and (5) health care services for miscarriages. An abortion procedure for the termination of a mother's pregnancy is covered only if: (1) the pregnancy is considered a life-threatening complication of the mother's existing physical illness; and (2) the abortion procedure is permitted by, and performed in accordance with, law.

e. Diagnostic radiology and laboratory services directly provided to you for radiology and lab tests related to covered physical illness or injury.

f. Radiation therapy and chemotherapy services for therapeutic treatment of covered benign or malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

g. Oral surgical services, including related consultation, x-rays and anesthesia, limited to the following procedures:

(1) surgical removal of impacted, sound natural unerupted teeth;

(2) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(3) surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(4) apicoectomy (excision of the apex of the tooth root);

(5) treatment of fractures of facial bones;

(6) excision of exostosis (bony outgrowth) of the jaws and hard palate;

(7) frenectomy (the cutting of tissue in the middle of the tongue);

(8) incision and drainage of cellulitis (tissue inflammation) of the mouth;

(9) incision of accessory sinuses, salivary glands or ducts;

(10) gingivectomy (excision of gum tissue to eliminate infection), but not including restoration of gum tissue or soft tissue Allograft;

(11) alveolectomy;

(12) osseous surgery;

(13) reduction of fractures and dislocation of the jaw; and

(14) functional osteotomies.

h. Emergency medical care in connection with a physical illness or injury.

i. Emergency medical care in connection with a physical illness.

j. Allergy testing, treatments, materials and injections.

2. Hospital Services.

Benefits are payable for charges for the following hospital services. This paragraph 2. does not include services for the treatment of mental health disorders, chemical dependency and substance abuse (please see subsection "Treatment of Mental Disorders, Chemical Dependency and Substance Abuse") and for organ transplants (please see paragraph 8. of this subsection).

a. Inpatient hospital services for a physical illness or injury up to a benefit maximum of 365 days per confinement:

(1) Charges for room and board for occupancy of a semiprivate room or lesser accommodations. If a participant is a patient in a one-bed private room, benefits are payable for the hospital's average daily rate for all its semiprivate rooms;

(2) Nursing services;

(3) Charges for miscellaneous hospital expenses; and

(4) Charges for intensive care unit room and board.

With respect to confinements for pregnancy, the Plan shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for a cesarean delivery. However, a participant is free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

b. Miscellaneous hospital expenses for a physical illness or injury received by a participant while he/she is not confined in a hospital as follows:

(1) health care services provided in connection with and on the day of a surgical procedure performed on an outpatient basis;

(2) emergency medical care for a non-occupational injury, if provided within 72 hours after such injury occurs;

(3) health care services incurred within five days immediately preceding a period of hospital confinement of at least three days duration for lab tests or x-rays for diagnostic purposes in connection with a physical illness or injury from which the confinement results, if the test would have been covered if performed while hospital confined;

(4) emergency medical care for a physical illness;

(5) radiation, speech, respiratory, physical and occupational therapy and chemotherapy;

(6) diagnostic x-ray and laboratory tests for diagnostic purposes in connection with an illness or injury which are ordered by the attending physician. This does not include x-ray examinations of the teeth;

(7) routine x-ray and laboratory services.

c. Facility fees charged by the hospital for office visits and for urgent care visits.

3. Other Covered Health Care Services.

Benefits are payable for charges for the following health care services:

a. Physical, speech, occupational and respiratory therapy performed in an office setting (other than a hospital). The therapy must be expected to significantly improve a participant's physical health within 60 days of the date on which such therapy begins. The therapy must be performed by a physician, licensed physical, speech, occupational or respiratory therapist, or any other health care provider approved by the Claim Administrator. The licensed physical, speech, occupational or respiratory therapist or other health care provider must be providing the therapy under the direction of a participant's physician. If a license to perform such therapy is required by law, that therapist or other health care provider must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for a participant's temporomandibular joint disorder is not covered under this paragraph.

b. Licensed professional ambulance services for emergency medical care and transportation to the nearest hospital where appropriate medical care is available. Subject to the annual deductible amount stated in paragraph 1. of subsection "Annual Deductible Amount", benefits are payable at 90% of the charges. Transportation undertaken to secure treatment by a personal physician or by a physician or institution of greater renown or greater specialization is not covered.

The Claim Administrator's prior approval is required for non-emergency licensed professional ambulance services to transport a participant from a hospital or other health care facility to another hospital or health care facility. If a participant does not receive the Claim Administrator's prior approval, benefits for such services are not payable under the Plan and such services are not covered.

c. Blood and blood plasma.

d. Prosthetic devices and supplies, including the fitting of such devices, which replace all or part of: (1) an absent body part (including contiguous tissue); or (2) the function of a permanently inoperative or malfunctioning body part. The Plan does not cover dental prosthetics.

e. Casts; splints; strapping; orthopedic braces; and crutches. These don't include special shoes or devices to protect the feet unless the device is a permanent part of an orthopedic leg brace.

f. Oxygen; rental of or, at our option, purchase of equipment to administer oxygen and respiratory therapy equipment.

g. Medical supplies prescribed by a physician.

h. Rental of or, at the Claim Administrator's option, purchase of durable medical equipment such as, but not limited to: wheelchairs; hospital-type beds; and artificial respiration equipment. Coverage for such equipment and devices will be limited to the standard models as determined by the Claim Administrator. The participant is responsible for paying any amount in excess of the charge for the standard models. When the durable medical equipment is purchased, benefits are payable for subsequent repairs necessary to restore the durable medical equipment to a serviceable condition. If the durable medical equipment is rented, benefits are payable for charges up to the purchase price of that durable medical equipment. Rental fees exceeding the purchase price, routine periodic maintenance, and replacement of batteries are not covered.

i. Dental services. Benefits are payable for charges for the following dental services: (1) dental repair of a participant's sound natural teeth due to an injury, provided treatment begins within 90 days of the injury; (2) extraction of seven or more sound natural teeth at one time; (3) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (4) sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease.

j. Immunizations. Benefits are payable as follows for immunizations including, but are not limited to, diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella. Immunizations for travel purposes are not covered. The annual deductible amounts do not apply to this paragraph 3. j.

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(1) for immunizations provided by a preferred provider, benefits are payable at 100% of the charges; and

(2) for immunizations provided by a health care provider other than a preferred provider, benefits are payable at 100% of the charges for immunizations for a dependent child who is a participant from birth through age six. Benefits for immunizations provided to members over age six are not covered.

k. Preventive services. Benefits are payable at 100% of the charges for the following preventive services when provided by a preferred provider:

(1) Routine medical exams, including eye exams, hearing exams, pelvic exams, and any related routine diagnostic services. Members age 18 and older are limited to one physical exam, hearing exam and eye exam per calendar year. This paragraph does not apply to health care services to treat an illness or injury.

(2) One pelvic exam, including pap smears, provided by any health care provider per participant per calendar year. Pelvic exams will be covered under this paragraph when directly provided to a participant by a physician, certified nurse midwife or a nurse practitioner.

(3) Prostate antigen testing, limited to participants age 45 and older or age 40 if prescribed by a physician.

The annual deductible and coinsurance amounts do not apply to this paragraph 3. k. Preventive services provided by a health care provider other than a preferred provider are not covered.

l. Outpatient cardiac rehabilitation services. Services must be directly provided to you in a facility with a facility-approved cardiac rehabilitation program. This coverage applies only to a member with a recent history of: (1) a heart attack (myocardial infarction); (2) coronary bypass surgery; (3) onset of angina pectoris; (4) onset of unstable angina; (5) onset of decubital angina; (6) heart valve surgery; (7) percutaneous transluminal

angioplasty or (8) another condition for which we determine cardiac rehabilitation as being appropriate for treating your medical condition. Benefits are payable only for an eligible member who begins an outpatient exercise program following his/her hospital confinement. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under the policy.

m. Intravenous (IV) therapy performed in your home if prescribed by a physician.

n. Initial pair of eyeglasses or external contact lenses: (1) for aphakia; (2) for keratoconus; and (3) following cataract surgery.

o. Blood lead tests for members age five and under.

p. Facility fees for health care services provided in a licensed free-standing surgical center.

q. Artificial insemination. We'll pay benefits for charges for artificial insemination (other than GIFT, in vivo or in vitro fertilization). Benefits shall be limited to three inseminations per menstrual cycle up to a maximum of 18 inseminations over any six month period.

r. Corneal transplants, bone grafts and skin grafts. We'll pay benefits for covered charges incurred by you for health care services directly provided to you for corneal transplants, bone grafts and skin grafts.

s. Private duty nursing provided by a nurse, registered, licensed or certified under the laws of the state in which the services are performed.

t. Breast reconstruction of the affected tissue following a mastectomy. Benefits are also payable for charges for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.

u. Hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a member in a hospital or ambulatory surgery center provided: (1) the member is a child under the age of five; (2) the member has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following area of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (3) the member has a medical condition that requires hospitalization or general anesthesia for dental care.

v. Certified nurse midwife services. We'll pay benefits for charges for covered services provided by a certified nurse midwife to a pregnant member if such services are within the lawful scope of their license and provided in a clinic or hospital.

w. Orthotics prescribed by a physician.

x. Routine foot care. We'll pay benefits for charges for routine foot care for members who are diagnosed with diabetes.

4. Kidney Disease.

Benefits are payable for charges for dialysis treatment up to a maximum benefit limit of $30,000 per calendar year. This maximum includes charges for kidney transplantation expenses payable under paragraph 8. of this subsection. Benefits are not payable for any charges paid for, or covered by Medicare.

5. Skilled Nursing Care in a Licensed Skilled Nursing Facility.

Benefits are payable for charges for skilled nursing care you receive in a licensed skilled nursing facility as follows if: (a) a participant is admitted to a licensed skilled nursing facility within 24 hours after discharge from a hospital; and (b) it's for continued treatment of the same illness or injury treated in the hospital. Benefits are payable for such skilled nursing care provided to the confined member at that facility for up to 120 days of confinement for that member. Benefits are payable only for the skilled nursing care which continues to treat the same illness or injury for which a participant had been treated at the hospital prior to his/her admission to that skilled nursing facility. Benefits are only payable for skilled nursing care which is certified as medically necessary by the participant's attending physician and is recertified as medically necessary every seven days and is not essentially domiciliary or custodial care. No benefits are payable for domiciliary care, maintenance care, supportive care, custodial care, or for care which is available at no cost to a participant or provided under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes, as amended).

6. Home Care Services.

a. Covered Services. This paragraph 6. applies only if charges for home care services are not covered elsewhere under the Plan. A Department-licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. A participant should make sure the agency meets this requirement before services are provided. Benefits are payable for charges for the following services:

(1) Part-time or intermittent home nursing care by or under supervision of a registered nurse;

(2) Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

(3) Physical or occupational therapy or speech-language pathology or respiratory care;

(4) Medical supplies, drugs and medications prescribed by a physician; laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if a participant had been hospitalized;

(5) Nutrition counseling provided or supervised by a registered or certified dietician; and

(6) Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. A participant's attending physician must request or approve this evaluation.

b. Limits on Home Care.

(1) Home care isn't covered unless a participant's physician certifies that: (a) hospitalization or confinement in a licensed skilled nursing facility would be needed if the participant didn't have home care; and (b) members of the participant's immediate family, or others living with him/her, couldn't give the participant the care and treatment he/she needs without undue hardship.

(2) If a participant was hospitalized just before home care started, his/her physician during his/her hospital confinement must also approve the home care plan.

(3) Benefits are payable for charges for up to 40 home care visits per participant per calendar year. Each visit by a person to provide services under a home care plan, or for evaluating a participant's need, or for developing a home care plan counts as one home care visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

(4) If home care is covered under two or more health insurance contracts, coverage is payable under only one of them, except as stated in Section "Coordination of Benefits".

(5) The maximum weekly benefit payable for home care won't be more than the benefits payable for the total weekly charges for skilled nursing care available in a licensed skilled nursing facility, as determined by the Claim Administrator.

7. Equipment and Supplies for Treatment of Diabetes.

Benefits are payable for charges incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies, excluding insulin and disposable diabetic supplies payable elsewhere under the Plan, used in the treatment of diabetes. This benefit is limited to the purchase of one pump per participant per calendar year. The participant must use the pump for at least 30 days before the pump is purchased. Benefits are also payable for charges for diabetic self-management education programs and diabetic shoes, but only if the program or diabetic shoes are medically necessary, as determined by the Claim Administrator. For coverage of insulin and certain disposable diabetic supplies, see paragraph 10. Prescription Legend Drug Coverage.

8. Certain Transplants.

This paragraph 8. applies only to transplant services provided by transplant preferred providers or any other health care provider approved by the Claim Administrator.

a. Covered Organ Transplant Procedures. Benefits are payable for charges for the health care services received for or in connection with the following transplants:

(1) heart;

(2) lung(s);

(3) heart-lung;

(4) liver;

(5) kidney;

(6) bone marrow;

(7) intestine;

(8) simultaneous pancreas/kidney;

(9) pancreas following kidney;

(10) any organ not listed above required by state or federal law.

Benefits for kidney transplantation expenses are payable up to a maximum benefit limit of $30,000 per participant per calendar year. This maximum includes kidney dialysis payable as stated in paragraph 4. of this subsection.

The term bone marrow identified above refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulated blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by the Claim Administrator.

The recipient must obtain and submit to the Claim Administrator a written opinion certifying the medical need for the transplant procedure. The opinion must be received by the Claim Administrator prior to transplant procedure. The opinion must be given by a board-certified medical specialist who is a physician. For solid organ transplants, the opinion must be provided by a board-certified surgeon. For bone marrow transplants, the opinion must be provided by a board-certified hematologist or board-certified oncologist. The board-certified medical specialist must certify that alternate procedures, services or courses of treatment would not be medically therapeutic in the treatment of the recipient's illness or injury.

b. **Covered Transplant Services.** Benefits are payable for charges for the following transplant services for approved transplants:

(1) health care services received from a hospital or physician and paid the same as any other physical illness;

(2) organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplant procedures will include costs associated with the donor-patient to the same extent and limitations associated with the participant, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program;

(3) direct, non-medical costs for the participant receiving the transplant will be paid for: (a) transportation to and from the hospital where the transplant is performed; and (b) temporary lodging at a prearranged location up to $75 per day when requested by the hospital and approved by the Claim Administrator, subject to the benefit maximum stated below. Transportation costs for the participant to and from the hospital where the transplant is performed will be paid at 90% of the covered expenses. These direct, non-medical costs are only available if the participant lives more than 100 miles from the transplant facility;

(4) direct, non-medical costs for one member of the participant's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the hospital where the transplant is performed; and (b) temporary lodging at a prearranged location during the participant's confinement in a hospital, not to exceed $75 per day, subject to the benefit maximum stated below. Transportation costs for the participant to and from the hospital where the transplant is performed will be paid at 90% of the covered expenses. These direct,

non-medical costs are only available if the participant's immediate family member(s) live more than 100 miles from the transplant facility.

All direct, non-medical expenses for the participant receiving the transplant and his/her family member(s) are limited to a combined maximum benefit limit of $10,000 per transplant.

c. Exclusions. No benefit is payable for or in connection with a transplant if:

(1) it is experimental, investigational or for research purposes as defined elsewhere in the Plan;

(2) the Claim Administrator is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the Claim Administrator;

(3) the Claim Administrator does not approve coverage for the transplant based on its established criteria;

(4) expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received;

(5) the expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan;

(6) the expense relates to the donation or acquisition of an organ for a recipient who is not covered under the Plan;

(7) a denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppresive drugs, and complications of such transplant;

(8) the participant for whom a transplant is requested has not met the pre-transplant criteria as established by the Claim Administrator; and

(9) transplants performed by a provider other than a transplant preferred provider, unless approved by the Claim Administrator.

9. Mammograms and Pap Smears.

Mammograms and pap smears must be performed by or under the direction of a physician, certified nurse midwife or licensed nurse practitioner. Benefits are payable for charges for the following:

a. one routine examination by low-dose mammography of a female member age 35 and over per calendar year;

b. routine taking and reading of pap smear or routine papanicolaou smear;

c. mammograms and pap smears provided in connection with an illness.

Benefits are payable at 100% of the charges for routine mammograms and pap smears when provided by a preferred provider. The annual deductible amounts do not apply to these routine mamograms and pap smears provided by a preferred provider.

10. Prescription Legend Drugs Coverage.

Benefits are payable for charges for prescription legend drugs, including insulin and certain disposable supplies, used to treat a participant's covered illness or injury as described in this paragraph 10. Benefits are available at a preferred pharmacy and through the mail order program.

a. Definitions. The following definitions apply to this paragraph 10. only:

Brand-Name Drug/Brand-Name Drugs: a prescription legend drug sold by the pharmaceutical company or other legal entity holding the original United States patent for that prescription legend drug. For purposes of the Plan, a brand-name drug may be classified as a generic drug if the Claim Administrator determines that drug is priced comparable to it's equivalent generic drug.

Copayment: the applicable amount shown below for each prescription order or refill for generic drugs, preferred brand-name drugs or brand-name drugs to be paid by a participant toward the purchase price charged by the provider for that drug, subject to the Claim Administrator's determination that the drug is a covered drug. The copayment applies to each separate prescription order or refill of a covered drug. Copayments will not apply to covered supplies. The copayments are the following when dispensed by a preferred pharmacy or through the mail order program:

(1) $5.00 for generic drugs, Prilosec OTC, Claritin and Claritin-D; (b) $20.00 for preferred brand-name drugs; and (c) $40.00 for brand-name drugs;

(2) Covered supplies: $20.00 copay.

Covered Drug/Covered Drugs: the following medically necessary drugs when dispensed by a provider: (a) any prescription legend drug; (b) any medicine the provider compounds which contains a prescription legend drug and that prescription legend drug or medicine is not excluded under the Plan; (c) oral contraceptives for birth control when dispensed by a provider; and (d) Prilosec OTC, Claritin and Claritin-D. This includes refills of covered drugs. In addition, the following conditions must be met as determined by the Claim Administrator:

(1) a prescription order by a physician is always made for it;

(2) a separate charge equal to, or more than the copayment is usually made for it; and

(3) it's not completely consumed at the time and place of the provider dispensing it under the prescription order.

Covered Supply/Covered Supplies: disposable diabetic supplies limited to the following: insulin syringes and needles, lancets, diabetic test strips, alcohol pads, dextrose (tablets and gel), auto injector, auto blood sampler, and glucose control solution.

Generic Drug/Generic Drugs: a prescription legend drug sold by a pharmaceutical company or other legal entity other than the one holding the original United States patent for that prescription legend drug. For purposes of the policy, a generic drug may be classified as a brand-name drug if the Claim Administrator determines that drug is priced comparable to its brand-name drugs.

Preferred Brand-Name Drug/Preferred Brand-Name Drugs: a brand-name drug stated in the list of preferred brand-name drugs that may change from time to time. The Claim Administrator will provide the participant with our most recent list of preferred brand-

name drugs which he/she should receive when he/she first becomes covered under this drug coverage under the Plan.

Preferred Pharmacy: pharmacies which have contracted to be preferred pharmacies and bill the Claim Administrator directly for the charges a participant incurs for covered drugs. These providers are listed in the most recent Preferred Pharmacy Directory furnished to a participant by the Claim Administrator.

Prescription Legend Drug: any medicine, including investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, for which the Federal Food, Drug and Cosmetic Act, as amended, requires its label to contain the wording: "Caution: Federal Law prohibits dispensing without prescription" or similar wording. Prescription legend drugs shall include insulin.

Prescription Order: the lawful written request made by a physician for dispensing a drug to a participant.

Provider: a pharmacy, pharmacist, physician, hospital or other entity with a license or registration to lawfully dispense prescription legend drugs to the member who receives the drug.

b. Benefits.

(1) Covered Drugs and Covered Supplies Dispensed by a Preferred Pharmacy. Subject to the applicable copayment amounts shown above, benefits are payable at 100% of the charges for each covered drug or covered supply dispensed by a preferred pharmacy and purchased by or for a participant while his/her coverage is in force under the Plan.

(2) Covered Drugs and Covered Supplies Dispensed by a Provider Other Than a Preferred Pharmacy. Subject to the applicable copayment amounts shown above, benefits are payable as follows for each covered drug or covered supply dispensed by a provider other than a preferred pharmacy and purchased by or for a participant while his/her coverage is in force under the Plan. A participant must first pay the purchase price charged by the provider for the covered drug or covered supply in order for him/her to obtain that covered drug or covered supply. Written proof of this payment must be sent to Medco Health as part of the proof of his/her drug claim. Subject to Medco Health's receipt of proof of the drug claim and the determination that the drug or supply is a covered drug or covered supply and that benefits are payable for that covered drug or covered supply, the Plan will pay to the participant the same benefit amount that would have been paid had the participant purchased the covered drug or covered supply from a preferred pharmacy. The participant is liable for the copayment and the difference, if any, between the Plan's benefit payment and the purchase price charged by the provider for that covered drug or covered supply in order for the participant to obtain that covered drug or covered supply.

If a participant does not identify himself/herself to the preferred pharmacy as a participant having this drug coverage under the Plan by showing his/her ID card and he/she pays the purchase price charged by the provider for the drug, the participant's drug claim will be handled as if the drug was dispensed by a provider other than a preferred pharmacy as described in (2) above.

If for a participant's illness or injury, there is more than one prescription legend drug to treat that illness or injury, a trial of the least expensive prescription legend drug is required

before benefits are payable under the Plan for any other alternative prescription legend drug.

c. **Preauthorization.** Certain drugs require preauthorization from the Claim Administrator prior to the provider dispensing the drug to a participant. A list of the most recent drugs requiring preauthorization is shown in the General Information section of the member guide. Since this list may change from time to time, the participant should contact the Claim Administrator by calling the Customer Service telephone number shown on his/her Identification Card to verify that the drug requires preauthorization.

If a drug requires preauthorization, a participant must call the Customer Service telephone number shown on his/her Identification Card. The Claim Administrator will then inform the participant of the specific information that the Claim Administrator needs in order to determine if the Claim Administrator can preauthorize the drug, such as a letter from the participant's physician explaining and documenting the medical necessity of the participant taking that drug for his/her illness or injury along with copies of all corresponding medical records and reports for his/her illness or injury. After the Claim Administrator's receipt of the required information, the Claim Administrator will review the information to determine if the drug is a covered drug and if benefits are payable for that covered drug, including, but not limited to, if that drug is medically necessary for the participant's illness or injury. If the Claim Administrator determines that the drug is a covered drug and that benefits are payable for that covered drug, including that the drug is medically necessary for the participant's illness or injury, the Claim Administrator will notify the participant and the administrator that does the Plan's drug claims processing that the benefits for the covered drug are payable under the Plan. If the Claim Administrator determines that the drug is not a covered drug or that the drug is not medically necessary, no benefits will be payable under the Plan for that drug.

If a participant wishes to obtain the drug prior to his/her receipt of the Claim Administrator's preauthorization, he/she must first pay the provider the purchase price charged by that provider for the drug. Written proof of his/her payment must be sent to the Claim Administrator's Customer Service Department along with the same information that the Claim Administrator would have required had the participant followed the preauthorization process stated above. After the Claim Administrator's receipt of the required information, the Claim Administrator will review the information to determine if the drug is a covered drug and if benefits are payable for that covered drug, including, but not limited to, if that drug is medically necessary for the participant's illness or injury. If the Claim Administrator determines that the drug is a covered drug and that benefits are payable for that covered drug, including that the drug is medically necessary for the participant's illness or injury, the Claim Administrator will pay the available benefits to the participant subject to all other terms, conditions and provisions of the Plan. If the Claim Administrator determines that the drug is not a covered drug or that the drug is not medically necessary for the participant's illness or injury, no benefits shall be payable under the Plan for that drug.

d. **Use of Brand-Name Drugs When Equivalent Generic Drugs Are Available.** If a participant purchases and receives a brand-name drug and the Claim Administrator determines that a generic drug equivalent to that brand-name drug is available for the participant's illness or injury from that provider, the participant is liable for and must pay the difference in cost between the purchase price of the equivalent generic drug and the purchase price of that brand-name drug charged by that provider for those drugs, in addition to the generic drug copayment. This limitation does not apply if the participant's physician written instructions state "dispense as written" or any instruction that the participant use only the brand-name drug. But if the substitution of that equivalent generic drug for that brand-name drug is prohibited by any applicable state law or an equivalent generic drug does not exist for the participant's illness or injury, the brand-name drug

copayment will apply and he/she will not be required to pay the difference in cost between the purchase price charged by that provider for those two drugs.

e. **Exclusions.** The following aren't covered under this paragraph 10. The Plan provides no benefits for:

(1) administration of a covered drug by injection or other means;

(2) devices, appliances or durable equipment, except for covered supplies;

(3) refills of covered drugs which exceed the number the prescription order calls for; or refills of covered drugs after one year from the date of such order;

(4) covered drugs usually not charged for by the provider; or a covered drug for which the provider's actual charge billed for the covered drug is less than the copayment;

(5) covered drugs for which benefits are paid elsewhere under the Plan;

(6) covered drugs completely consumed at the time and place of the provider's dispensing the drugs under the prescription orders;

(7) anabolic steroids;

(8) progesterone crystals and powder in any compounded dosage form;

(9) costs related to the mailing, sending or delivery of prescription legend drugs;

(10) prescription or refill of drugs, medicines, medications or supplies that are lost, stolen, spilled, spoiled or damaged;

(11) any drug or medicine that is available in prescription strength without a prescription;

(12) more than one prescription for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more providers until at least 75% of the previous retail prescription has been used by the participant. If the covered supply, drug or therapeutic equivalent medication is dispensed at a mail order service, then at least 60% of the previous prescription must have been used by the participant;

(13) Anorectics (any drug used for the purpose of weight loss). Exceptions: Amphetamine/Dextroamphetamine (e.g. Adderall) and Dextroamphetamine (e.g. Dexedrine) are covered for treatment of morbid obesity; and

(14) Drugs and medicines not covered under the Plan. Please see Section “General Exclusions”.

g. **Limitations.** For covered drugs and covered supplies not purchased by mail order, benefits are limited to a 30-day supply at one time. For mail order covered drugs and covered supplies, benefits are limited to a 90-day supply at one time.

11. Temporomandibular Joint Disorders (TMJ).

a. **Benefits.** Benefits are payable for charges for the following:

(1) oral surgical services, including anesthesia services for surgical correction of a participant's temporomandibular joint disorder (TMJ), including arthroscopy, arthrotomy, meniscectomy, condylectomy, coronoidectomy, excision of, and reduction for dislocation of, the temporomandibular joint.

(2) health care services, other than those stated in (1) above, for a participant's temporomandibular joint disorders (TMJ Syndrome), subject to the maximum benefit limit of $1,250 per participant per calendar year. Such health care services must not permanently alter the teeth or bite and include: (a) history, exam and diagnosis; (b) diagnostic services, such as but not limited to: x-rays, magnetic resonance imaging (MRI) and computed tomography (CT) scans; (c) splinting and adjustments, including, muscle relaxation appliances; anterior repositioning appliances; and pivotal appliances; (d) rental of, or at our option, purchase of a transcutaneous nerve stimulation (TENS) unit; (e) biofeedback; and (f) physical therapy.

No other coverage for a participant's temporomandibular joint disorder is available under the Plan.

b. **Exclusions.** The following aren't covered under this paragraph 11. The Plan provides no benefits for:

(1) dental treatment, services and supplies for temporomandibular joint disorder which permanently alter the teeth or bite, including but are not limited to: orthodontics; restorative crowns; and bridgework;

(2) behavioral modification;

(3) postural training;

(4) hypnosis therapy;

(5) health care services not covered under the Plan. Please see Section "General Exclusions".

12. Alternative Care.

Sometimes a participant's attending physician may advise him/her to consider an alternative course of treatment or confinement for a covered illness or injury which differs from his/her current course of treatment or confinement for that covered illness or injury and includes health care services not covered under the Plan. The participant's attending physician should contact the Claim Administrator so the Claim Administrator can discuss it with him/her. The Claim Administrator, at its option, will consider paying benefits under the Plan for charges for such health care services as long as such health care services are medically necessary to treat the participant's illness or injury. Payment of benefits, if any, shall be made as determined by the Claim Administrator, at its option. The Claim Administrator may consider an alternative care plan if the alternative care is not subject to an exclusion of the Plan and it appears that:

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

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

c. the charges incurred for health care services to be provided under the alternative course of treatment or confinement to its end will be less than those charges for health care services to be provided under the current course of treatment or confinement to its end.

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

Any alternative care decision must be approved by the Claim Administrator , the participant and the attending physician before the participant's alternative course of treatment or confinement begins. Any additional treatment or confinement beyond the agreed to alternative course of treatment or confinement must be reviewed and reconsidered by the Claim Administrator and approved by the Claim Administrator , the participant and the attending physician.

The Claim Administrator will send a letter to the participant and his/her attending physician. This letter will provide:

a. the alternative course of treatment or confinement;

b. the projected costs for such treatment or confinement; and

c. the benefits payable under the Plan for charges incurred for such course of treatment or confinement.

The benefits payable will first be paid as provided under the Plan. In the event that the alternative course of treatment or confinement includes health care services not covered under the Plan, the Claim Administrator, at its option, will consider paying benefits under the Plan for charges for such health care services as long as such health care services are medically necessary and the original course of treatment would have been covered under the Plan to treat the participant's covered illness or injury. Payment of benefits, if any, shall be made as determined by the Claim Administrator , at its option.

13. Hospice Care Services.

Benefits are payable for charges for covered expenses for hospice care services provided to a terminally ill participant if the participant's health condition would otherwise require his/her confinement in a hospital or a skilled nursing facility and hospice care is a cost effective alternative, as determined by the Claim Administrator. Hospice care services include services provided by a licensed public agency or private organization intended primarily to provide pain relief, symptom management, and medical support services to persons who are terminally ill. Hospice care services may be provided at hospice facilities or in the participant's place of residence.

Covered expenses for hospice care services shall include: (a) room and board at a hospice facility while the participant is receiving acute care to alleviate physical symptoms of his/her terminal illness; (b) physician and nursing care; and (c) services provided to the participant at his/her place of residence. Room and board for residential care at a hospice facility is not covered.

Benefits are payable for charges for covered expenses for hospice care services provided to the participant during the initial six-month period immediately following the diagnosis of a terminal illness for that participant. Coverage for hospice care services to be provided to that participant after the initial six-month period will be extended by the Claim Administrator under the Plan beyond the initial six month period, provided, a physician certifies in writing that the participant is terminally ill.

Treatment of Mental Disorders, Chemical Dependency and Substance Abuse

The benefits under this subsection are administered by Health Management Center, Inc. ("HMC").

1. Definitions.

The following definitions apply to this subsection only:

Acute: the sudden onset or abrupt change of a mental health condition requiring prompt attention, but which is of limited duration, as determined by HMC.

Authorization: a decision in writing by HMC that benefits are payable for certain services that a participant will receive or have received under the Plan. Requests for authorization will be denied if not medically necessary or are otherwise not covered under the Plan.

Behavioral Healthcare Services: chemical dependency, substance abuse and/or mental healthcare services which are covered under the Plan.

Chemical Dependency or Substance Abuse: a psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and medically necessary treatment as determined by HMC. Chemical dependency does not include addiction to or dependency on nicotine or food substances in any form.

Covered Charges: payment for covered services furnished in connection with the treatment of chemical dependency or mental disorders as follows:

a. individualized evaluation of needs, referral into treatment and monitoring by HMC;

b. medically necessary inpatient treatment and residential treatment center room and board;

c. other chemical dependency or mental disorder services and supplies medically necessary for the treatment of the participant, subject to authorization by HMC;

d. medically necessary practitioner services received at hospitals and facilities;

e. medically necessary practitioner services for individual, group and family therapy or counseling.

Diagnostic and Statistical Manual of Mental Disorders (DSM): a listing of diagnostic categories and criteria which provides guidelines for making diagnoses of mental disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of mental disorder is a minimum requirement for the demonstration of medical necessity. The diagnosis must be contained in the most recent edition of the DSM.

Facility: a health or residential treatment center which is duly licensed by the state in which it operates to provide inpatient, residential day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of chemical dependency and/or mental disorders.

Mental Disorder: a mental disorder is a nervous or mental condition that meets all of the following conditions:

a. it is a clinically significant behavioral or psychological syndrome or pattern;

b. it is associated with a painful symptom, such as distress;

c. it impairs a patient's ability to function in one or more major life activities;

d. it is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Mental Healthcare Services: those services determined by HMC to be medically necessary for the treatment of a mental disorder.

Mental Retardation: subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both.

Outpatient: a member receiving covered services who has not been admitted to a hospital or facility.

Partial Hospitalization or Day Treatment Center: a facility designed to meet the needs of those participants who no longer need the structure provided by hospitalization. The day treatment center also meets the needs of those participants who do not require the intensity of an inpatient program and 24-hour supervision but require a structured program of therapeutic intervention.

Participating Provider: the practitioner, hospital or facility is participating in HMC's network, meets HMC's credentialing standards and has agreed, by signing a Participating Provider Agreement with HMC, to accept the provisions of the applicable agreement, including contractually agreed upon compensation, as the total charge, whether paid fully by HMC or requiring cost sharing by the participant.

Practitioner: a psychiatrist, licensed psychologist, licensed clinical social worker or a marriage family therapist who is duly licensed or certified under the laws of the State where treatment is delivered.

Residential Treatment Center: a supervised line-in treatment program for those individuals who require 24-hour supervision in a non-medical setting.

Session: any in-person or telephone consultation with a practitioner for covered services under the Plan.

Service Area: the geographic area in which participating providers are located.

Transitional Treatment: a planned, medical therapeutic program for members with mental disorders. This includes diagnosis, medical care, and treatment when the participant does not require full-time, inpatient, acute hospitalization, but does need more intensive care than traditional outpatient sessions.

2. Preauthorization.

A participant MUST contact HMC at 1-800-472-4992 prior to receiving inpatient services, outpatient services or day treatment (transitional services). If a participant does not contact HMC prior to receiving services, benefits are not payable for the benefits described in this subsection.

If the chemical dependency or mental healthcare services are medically necessary, HMC will refer a participant to an appropriate health care provider for his/her condition. HMC will contact the health care provider regarding the initial authorized covered services. The health care provider may be issued an authorization letter describing the authorized treatment.

Concurrent reviews typically occur on a regular basis throughout your treatment. During such reviews, HMC monitors the participant's course of treatment to determine the necessity of continuous stay or sessions and appropriateness of the level of care. For maximum reimbursement,

HMC must authorize all extended lengths of stay and transfers to different levels of care as well as any ancillary services.

Admission directly from the emergency room do not require preauthorization. However, notification is required within two business days after the admission or as soon as reasonably possible. Participating providers will notify HMC of a participant's admission. If a participant is admitted to a hospital or facility other than a participating provider, the participant is responsible for notifying HMC by calling the number stated above. Failure to notify HMC of an emergency admission to a non-participating provider within two business days after the admission, or as soon as reasonably possible, will result in a denial or reduced level of coverage.

3. Benefits for Treatment of Mental Disorders, Chemical Dependency and Substance Abuse.

HMC will pay benefits for covered charges as stated below for services furnished in connection with the treatment of chemical dependency or mental disorders. Services must be medically necessary and incurred while coverage is in force under the Plan.

a. Inpatient Mental Health and Substance Abuse Treatment.

(1) Inpatient Mental Health and Substance Abuse Treatment Provided by a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 80% of the charges for covered expenses a participant incurs for inpatient mental health and substance abuse treatment provided to a participant by a participating provider up to the maximum benefit limit stated in (3) below.

(2) Inpatient Mental Health and Substance Abuse Treatment Provided by a Health Care Provider Other Than a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 50% of the amount that would have been paid if an HMC provider provided the service for covered expenses a participant incurs for inpatient mental health and substance abuse treatment provided to a participant by a health care provider other than a participating provider up to the maximum benefit limit stated in (3) below. Benefits payable in this paragraph are subject to a $50 deductible per confinement.

(3) Maximum Benefit Limit. Total benefits payable under (1) and (2). above shall not exceed the maximum benefit limit of 30 days per participant per calendar year.

b. Outpatient Mental Health and Substance Abuse Treatment.

(1) Outpatient Mental Health and Substance Abuse Treatment Provided by a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 95% of the charges for covered expenses a participant incurs for outpatient mental health and substance abuse treatment provided to a participant by a participating provider up to a maximum benefit limit of 25 sessions per participant per calendar year.

(1) Outpatient Mental Health and Substance Abuse Treatment Provided by a Health Care Provider Other Than a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 50% of the amount that would have been paid if an HMC provider provided the service for covered expenses a participant incurs for outpatient mental health and substance abuse treatment provided to a participant by a health care provider other than a preferred provider up to a maximum benefit limit of 15 sessions per participant per calendar year.

c. Transitional Treatment Arrangements (Partial Hospitalization, Day Treatment Center and Residential Treatment Center).

(1) Transitional Treatment Arrangements Provided by a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 95% of the charges for covered expenses a participant incurs for transitional treatment arrangements provided to a participant by a participating provider up to the maximum benefit limit stated in (3) below.

(2) Transitional Treatment Arrangements Provided by a Health Care Provider Other Than a Participating Provider. Subject to the preauthorization requirement stated in 2. above, benefits are payable at 50% of the amount that would have been paid if an HMC provider provided the service for covered expenses a participant incurs for transitional treatment arrangements provided to a participant by a health care provider other than a participating provider up to the maximum benefit limit stated in (3) below.

(3) Maximum Benefit Limit. Total benefits payable under (1) and (2). above shall not exceed the maximum benefit limit of 30 days per participant per calendar year.

No benefits are payable for: (a) charges for outpatient services provided to or received by a participant as a collateral of a patient which do not enhance the outpatient treatment of another participant who is also covered under the Plan; or (b) marriage counseling.

In no event will the benefits payable under this paragraph 3. be less that those benefits required by Wisconsin law.

4. Exclusions.

The following aren't covered under this subsection. The Plan provides no benefits for:

a. treatment of detoxification in newborns;

b. treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's Disease, Mental Retardation (other than initial diagnosis), Organic Brain Disease, Delirium, Dementia, Amnesiac Disorders and Other Cognitive Disorders as defined in the DSM;

c. treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders;

d. treatment of obesity and eating disorders unless otherwise required by law. This does not include the diagnosis of anorexia and bulimia nervosa as defined in the DSM;

e. court-ordered testing and treatment;

f. private hospital rooms and/or private duty nursing, unless determined to be medically necessary and authorization by the HMC Medical Director or his/her designee is obtained;

g. ancillary services such as: (1) vocational rehabilitation; (2) behavioral training; (3) speech or occupational training; (4) sleep therapy and employment counseling; (5) training or educational therapy for reading or learning disabilities; (6) other education services.

h. testing, screening or treatment for:

(1) Learning Disorders, Expressive Language Disorders, Mathematics Disorder, Phonological Disorder and Communication Disorder NOS;

(2) Motor Skills Disorders and Developmental Coordination Disorder;

(3) All Disorders of Infancy and Early Childhood and Developmental Disorders including, but not limited to, Communication Disorders, Pervasive Developmental Disorders, Autistic Disorder, Rett's Disorder, Asperger's Disorder (except as otherwise required by law);

(4) disorders resulting from general medical conditions, including, but not limited to, Catatonic Disorder Due to General Medical Condition, Personality Change Due to General Medical Disorder, Narcolepsy, Stuttering, Stereotypic Movement Disorders, Sleep Disorders, TIC Disorders, Elimination Disorders, Sexual Dysfunctions, Primary Insomnia;

(5) Personality Disorders;

(6) Pedophilia;

(7) Primary Sleep Disorders, Primary Hypersomnia and Dyssomnia NOS;

(8) Age-Related Cognitive Decline;

i. treatment of conditions which are medical in nature, even when such conditions may have been caused by a mental disorder, chemical dependency or substance abuse;

j. treatment by practitioners other than those within licensing categories then recognized by HMC as providing covered services in accordance with applicable medical community standards;

k. treatment provided for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded unless otherwise specified in this subsection);

l. services in excess of those with respect to which authorization is obtained;

m. psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports;

n. missed appointments. HMC will consider one of the participant's counseling sessions used if the participant fails to cancel with the practitioner at least 24 hours in advance, unless the appointment is missed because of an emergency or circumstances beyond the participant's control;

o. all prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with the participant's treatment as an inpatient at a hospital or as a patient at a facility providing alternate treatment;

p. inpatient health care services provided without authorization, if required, except in the event of an emergency;

q, damage to a hospital or facility caused by a participant;

r. treatment for biofeedback, acupuncture or hypnotherapy;

s. health care services not covered under the Plan. Please see Section "General Exclusions".

5. Submitting Claims.

All claims for the treatment of alcoholism, drug abuse and nervous or mental disorders are processed by HMC. Please mail all claims or correspondence to HMC/MHN, P.O. Box 14621, Lexington, Kentucky 40512-4621.

COST CONTAINMENT

This section does not apply to: (1) confinements for maternity, alcoholism, drug abuse or nervous or mental disorders; and (2) confinements covered by Medicare (unless the Plan's benefits are primary to Medicare).

Preadmission and Continued Stay Certifications

1. Preadmission Certification.

a. **For Non-Emergency Admissions.** A participant's attending physician may recommend that he/she be admitted to a hospital for: (1) non-emergency surgery; (2) treatment; (3) diagnosis; or (4) tests. If so, the participant or his/her family member, physician, hospital or other health care provider on his/her behalf must notify the Claim Administrator's Value Care Department at least three business days prior to the proposed admission date. The notice must be in writing or given by telephone and provide the following information:

(1) patient information: name; birth date; WPS customer and group numbers; phone number; and address;

(2) customer information: name; customer and group numbers; employer or health plan and their address;

(3) the diagnosis with related symptoms and their duration;

(4) results of: physical exam; lab tests; and x-rays;

(5) the treatment plan for the patient;

(6) physician information: name; tax ID or social security number; phone number; address; and medical specialty;

(7) name, address and phone number of the facility to which the patient will be admitted;

(8) the number of inpatient days the physician feels will be needed;

(9) the proposed admission date; and

(10) the date of any proposed surgery or procedure.

If the participant or his/her family member, physician, hospital or other health care provider on his/her behalf fails to notify the Claim Administrator of the proposed hospitalization in advance as required above, benefits otherwise payable for the participant's confinement will be reduced in accordance with paragraph 3. below.

If the participant, or his/her family member, physician, hospital or other health care provider on his/her behalf, fails to provide the information listed above to the Claim Administrator at least three business days prior to the proposed admission date, the Claim Administrator may not be able to complete its certification review prior to the date of the participant's admission to the hospital. If the Claim Administrator's review isn't completed by the date of the participant's admission to the hospital because the Claim Administrator didn't receive the notice in advance as required above, the admission may not be certified as medically necessary. No benefits are payable for the participant's confinement in a hospital or any hospital days thereof which the Claim Administrator determines are not medically necessary.

The proposed admission may be reviewed by the Claim Administrator in consultation with the participant's attending physician, provided the physician is available for such consultation. The Claim Administrator will determine the number of hospital days for which benefits for charges for covered expenses will be payable under the Plan. The Claim Administrator may certify less than the number of hospital days proposed by the physician if it determine that the number of days proposed are not medically necessary. The Claim Administrator may also determine that the proposed admission is not medically necessary for the participant. No benefits are payable for confinements or any hospital days thereof which the Claim Administrator determines are not medically necessary.

The participant's attending physician may feel there are extenuating circumstances or additional information not available to the Claim Administrator which medically justifies the hospitalization and/or additional days of confinement. If so, he/she should immediately notify the Claim Administrator accordingly. The Claim Administrator will review its decision in light of any such extenuating circumstances and/or additional information. Within one business day of the Claim Administrator's receipt of such information, the Claim Administrator will notify the participant, the physician and hospital of any change in its original decision.

After the decision is made, the participant, the physician and hospital will be notified in writing by the Claim Administrator of its decision. The Claim Administrator's letter will state whether or not the proposed admission has been certified and, if so, the number of hospital days certified as being medically necessary for the participant.

b. **For Emergency Admissions.** If a participant is admitted to a hospital on an emergency basis, the Claim Administrator must be notified in writing or by telephone within two business days after the date of admission. The participant, or his/her family member, physician, hospital or other health care provider on his/her behalf, must provide the same information as required for non-emergency admissions. The admission may be reviewed by the Claim Administrator in consultation with the physician, provided the physician is available for such consultation. The Claim Administrator will determine the number of medically necessary hospital days for which benefits are payable under the Plan. The Claim Administrator may certify less than the number of hospital days proposed by the physician if the Claim Administrator determines that the number of days proposed are not medically necessary. The Claim Administrator may also determine that the proposed admission is not medically necessary for the participant. After the decision is made, the Claim Administrator will notify in writing the participant, the physician and hospital of its decision. No benefits are payable for confinement in a hospital or any hospital days thereof which the Claim Administrator determines are not medically necessary.

If the participant, or his/her family member, physician, hospital or other health care provider on his/her behalf, fails to notify the Claim Administrator of the emergency admission with two business days after the participant's admission as required above, benefits otherwise payable for the participant's confinement will be reduced in accordance with paragraph 3. below.

The participant's attending physician may feel there are extenuating circumstances or additional information not available to the Claim Administrator which medically justifies the hospitalization and/or additional days of confinement. If so, he/she should immediately notify the Claim Administrator accordingly. The Claim Administrator will review its decision in light of any such extenuating circumstances and/or additional information. Within one business day of the Claim Administrator's receipt of such information, the Claim Administrator will notify the participant, the physician and hospital of any change in its original decision./

2. Continued Stay Certification.

Prior to expiration of the total number of medically necessary hospital days originally certified by the Claim Administrator for a participant's emergency or non-emergency admission, the participant's attending physician or the hospital utilization review staff will be contacted by the Claim Administrator by telephone to determine if: (a) the participant has been discharged; or (b) the Claim Administrator needs to review the medical necessity of the participant's continued hospitalization beyond the number of hospital days originally certified by the Claim Administrator as being medically necessary. The Claim Administrator's certification of those additional days of confinement review will be performed in the same manner as its review of the participant's original hospital admission. Then the Claim Administrator will make a decision on the certification of the medical necessity of the number of additional days of confinement, if any. Such continued stay reviews may be performed by the Claim Administrator periodically until: (a) discharge occurs; or (b) the Claim Administrator determines that additional days of the participant's confinement may no longer be certified as medically necessary. If the participant remains confined in the hospital beyond the number of days certified by the Claim Administrator as being medically necessary, benefits are not payable for inpatient hospital services and related health care services directly provided to the participant which the Claim Administrator determines are not medically necessary, in accordance with paragraph 3. below.

3. Payment of Benefits.

If a participant, or the physician, hospital or other health care provider on his/her behalf, received the Claim Administrator's preadmission certification, benefits for charges for inpatient confinements are payable as described under the Plan. However:

a. If the participant's non-emergency admission occurs without the Claim Administrator being notified in advance in accordance with paragraph 1. a. above, benefits payable for charges for covered expenses for inpatient hospital services and related health care services directly provided to the participant, which the Claim Administrator determines are medically necessary, will be reduced by $100 for that confinement. No benefits are payable for inpatient hospital services and related health care services directly provided to the participant which the Claim Administrator determines are not medically necessary.

b. If the participant's emergency admission occurs without the Claim Administrator being notified in accordance with paragraph 1. b. above, benefits payable for charges for covered expenses for inpatient hospital services and related health care services directly provided to the participant, which the Claim Administrator determines are medically necessary, will be reduced by $100 for that confinement. No benefits are payable for inpatient hospital services and related health care services directly provided to the participant, which the Claim Administrator determines are not medically necessary.

c. If the participant remains confined in a hospital beyond the number of days certified by the Claim Administrator as being medically necessary in accordance with paragraph 2. above, benefits are not payable for inpatient hospital services and related health care services directly provided to the participant which the Claim Administrator determines are not medically necessary.

A participant may receive inpatient hospital services and related health care services after the Claim Administrator originally determines such expenses are not medically necessary. A participant may also receive inpatient hospital services and related health care services during hospital days which exceed the number of hospital days certified by the Claim Administrator as being medically necessary. Such expenses may later be eligible for benefits under the Plan if the Claim Administrator later determines on the basis of new information that such expenses are medically necessary for the participant.

Prenatal and Maternity Care Notification

Maternity admissions are not subject to the preadmission and continued stay certification requirements described above. However, if a participant is pregnant, the Claim Administrator requests that he/she also notify the Claim Administrator:

1. after his/her first prenatal visit; and

2. within 24 hours or the first business day following the date of his/her delivery.

Although the participant's failure to provide such notice won't reduce benefits otherwise payable for such health care services, his/her notice to the Claim Administrator will allow the Claim Administrator to work with the participant and her physician during her pregnancy to help coordinate medically necessary health care services and provide high-risk screening and health information.

Individual Case Management

1. Alternate Treatment.

From time to time the Claim Administrator may, at its option, suggest that a participant consider an alternate treatment of his/her covered illness or injury which differs from his/her current treatment of that illness or injury if it appears that the alternative treatment is not subject to an exclusion of the Plan and:

a. the alternate treatment offers a medical therapeutic value at least equal to the current treatment;

b. the current treatment may be changed without jeopardizing the participant's health; and

c. the charges incurred for services to be provided under the alternate treatment to its end will probably be less than those charges to be incurred for services to be provided under the current treatment.

The Claim Administrator will contact the participant's attending physician to: (a) suggest his/her consideration of the alternate treatment; (b) advise him/her of the possible benefits payable by the Plan for charges for such treatment; and (c) answer any questions the attending physician may have.

The Claim Administrator will then send a letter to the participant or his/her authorized representative and the attending physician. That letter will provide:

a. a description of the alternate treatment;

b. an estimate of the possible benefits payable by the Plan for the charges to be incurred for such treatment. Please see paragraph 3. below.

If the participant or his/her authorized representative and the attending physician agree to the alternate treatment, the letter must be signed by the participant or his/her authorized representative and his/her attending physician. The signed letter must be promptly returned to the Claim Administrator. The alternate treatment must begin as soon as reasonably possible. If the participant or his/her authorized representative and/or the attending physician do not agree with the alternate treatment, benefits for charges incurred for the current treatment remain payable as provided under the Plan. Acceptance of the alternate treatment does not prevent a change in treatment at any time thereafter.

2. Alternate Confinement.

From time to time the Claim Administrator may, at its option, suggest that a participant, while confined in a hospital for a covered illness or injury, consider his/her transfer to another institution if it appears that the alternative confinement is not subject to an exclusion of the Plan and:

a. the other institution can provide the necessary medical care;

b. the physical transfer would not jeopardize the participant's health and the medical effectiveness of the current treatment; and

c. the charges to be incurred for the alternate confinement at the other institution will probably be less than those charges to be incurred for continued confinement at the current hospital.

The Claim Administrator will contact the participant's attending physician to: (a) suggest his/her consideration of the alternate confinement; (b) advise him/her of the possible benefits payable by the Plan for charges for such confinement; and (c) answer any questions the attending physician may have.

3. Payment of Benefits.

Benefits are payable for charges incurred as described in 1. and 2. above as provided under the Plan. In the event that the alternate treatment and/or alternate confinement includes medical care and/or services for which benefits are not otherwise payable under the Plan, the Claim Administrator, at its option, will consider the payment of benefits under the Plan for charges incurred for such care and/or services as long as such treatment and/or confinement is medically necessary and the original course of treatment would have been covered under the Plan to treat the participant's covered illness or injury. Benefits, if any, shall be paid only as determined by the Claim Administrator.

Preauthorization Procedure

This section describes the types of health care services that should be preauthorized **but are not required to be preauthorized**.

Benefits are not payable for health care services that are experimental, investigative or not medically necessary or excluded from coverage due to an exclusion, as determined by the Claim Administrator. The Claim Administrator knows it is difficult for a participant to determine whether any non-emergency health care services will be covered before starting treatment. The types of health care services that may fall into this category, but not limited to these, are:

1. Transplants and implants of body organs, except as specifically stated in the Plan;

2. New medical or biomedical technology;

3. Methods of treatment by diet or exercise;

4. New surgical methods or techniques;

5. Acupuncture or similar methods;

6. Sleep studies; and

7. Sclerotherapy.

If a participant wants to submit a "preauthorization" request to the Claim Administrator, the participant can ask the Claim Administrator whether or not a health care service will be covered under the Plan. After the Claim Administrator receives a preauthorization request, the Claim Administrator will make a determination on whether or not to pre-authorize benefits for the health care service based upon the information available to the Claim Administrator at the time the Claim Administrator receives the preauthorization request. The Claim Administrator will send the participant its written response to his/her preauthorization request, telling the participant whether the health care service is covered.

However, even if a health care service is pre-authorized in writing by the Claim Administrator, no benefits will be paid unless after receiving the proof of claim, the Claim Administrator determines that benefits are payable for that pre-authorized health care service under the terms, conditions, exclusions, limitations, and all other provisions of the Plan and the participant's coverage is in effect at the time the health care service is provided to him/her. Even if a health care service is pre-authorized by the Claim Administrator under this section, benefits are still subject to all terms, conditions and provisions of the Plan.

The proof of claim may differ from the preauthorization request. This means that the Claim Administrator's preauthorization of benefits is not its final decision and does not guarantee payment of benefits later. This means that benefits may not be paid if, after reviewing the proof of claim, the Claim Administrator determines that the health care service is not covered under the Plan.

The Claim Administrator continuously reviews the medical necessity or experimental or investigative nature of various procedures. This may also impact the Claim Administrator's determination of the availability of benefits. An alternate course of treatment or confinement may be considered by the Claim Administrator under "Alternate Care" of the Plan.

If a participant does not use this preauthorization procedure, the Claim Administrator may decide that the health care service is either experimental, investigative, not medically necessary, that an exclusion applies, or that benefits are not payable for some other reason under the Plan. No payment can then be made for the health care service or any related health care service.

If a participant or his/her physician disagrees with the Claim Administrator's decision, he/she may appeal that decision by submitting to the Claim Administrator documentation from the treating physician as to the medical value or effectiveness of the health care service. Please see subsection "Claim Appeal Procedure". If a participant uses that appeal procedure, the decision made by the Claim Administrator at that time will be final.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS FOR LATE ENROLLEES

Within six months prior to a participant's effective date of coverage under the Plan, he/she may have: (1) had an illness or injury diagnosed; (2) received care, medical services or treatment, including receipt of prescription legend drugs, for an illness or injury; (3) received medical advice for an illness or injury; or (4) had care, medical services or treatment recommended for an illness or injury. If so, benefits are not payable for expenses incurred as a result of that illness or injury and any complications of any such illness or injury until the participant has been covered under the Plan for 270 days in a row. No benefits are payable for charges for treatment, services, supplies or other expenses incurred during the waiting period for any such illness or injury and any complications of any such illness or injury. Charges for covered expenses for treatment of a pre-existing illness or injury and any complications of any such illness or injury which are incurred after the expiration of the waiting period for it are eligible for benefits as provided under the Plan. If a dependent child is born or is legally adopted by a participant while he/she has family coverage under the Plan, the child doesn't have a waiting period for any such illness or injury.

The Claim Administrator will shorten the 270-day waiting period stated above for a participant by:

1. the number of days he/she was continuously covered for such illness or injury under any creditable prior coverage that was not followed by a break of more than 63 days or more in coverage between the time the creditable prior coverage terminated and the enrollment date of coverage under the Plan; and

2. the number of days from the date the Claim Administrator received the completed application to the participant's effective date as determined by the Claim Administrator.

The waiting periods for pre-existing conditions described above do not apply to:

1. Treatment, services and supplies in connection with pregnancy; or

2. An eligible dependent child under the age of 18 who has creditable prior coverage that was not followed by a break of 63 days or more in coverage.

GENERAL EXCLUSIONS

The following aren't covered under the Plan. The Plan provides no benefits for:

1. Health care services provided in connection with any injury or illness arising out of, or in the course of, any employment for wage or profit for which an employer is required to carry workers' compensation insurance. If workers' compensation laws or any similar laws apply to a participant, this exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived or compromised, or whether a participant is covered under workers' compensation insurance.

This exclusion does not apply to health care services provided in connection with any injury or illness arising out of, or in the course of, any employment for wage or profit: (a) by a sole proprietor or partner if they elect not to become an employee under Section 102.075, Wisconsin Statutes, as amended; or (b) by a corporate officer if they elect not to become an employee under Section 102.076, Wisconsin Statutes, as amended; or similar laws of the state in which the

participant/member works. The sole proprietor, partner or corporate officer must provide the Claim Administrator with written proof of such election.

2. Health care services furnished by the U.S. Veterans Administration, except for such health care services for which under applicable federal law the Plan is the primary payer and the U.S. Veterans Administration is the secondary payer.

3. Health care services furnished by any federal or state agency or a local political subdivision when a participant is not liable for the costs in the absence of insurance, unless such coverage under the Plan is required by any state or federal law.

4. Health care services covered by Medicare, if a participant has or is eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law the Plan is the primary payer and Medicare is the secondary payer. Please also see subsection “Coverage With Medicare”.

5. Health care services for any injury or illness caused by: (a) atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile.

6. Cosmetic treatment or surgery.

7. Reconstructive surgery, except for such surgery required: (a) to repair a significant defect caused by an injury; (b) to repair a defect caused by congenital anomaly causing a functional impairment of a dependent child; (c) incidental to a mastectomy; or (d) due to a physical illness.

8. Health care services which aren't medically necessary for the treatment of an illness or injury, as determined by the Claim Administrator.

9. Medical exams, including eye exams and hearing exams, health assessments, procedures and associated services requested by a third party. Such examples include, but are not limited to: (a) exams for insurance, school, employment or camp; and (b) exams directed or requested by a court of law, except for court ordered nervous or mental disorder exams to the extent benefits are payable in the Plan.

10. Preparation, fitting, or purchase of eyeglasses or contact lenses, except as specifically stated in the Plan; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery.

11. Health care services provided at any nursing facility or convalescent home or expense in any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in the Plan.

12. Custodial care or rest care.

13. Health care services which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended.

14. Medical supplies and durable medical equipment for a participant’s comfort, personal hygiene or convenience, including, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

15. Health care services for, or leading to, sex transformation surgery, the sex transformation surgery, and sex hormones related to such surgery.

16. Reversal of sterilization.

17. Therapy services such as recreational therapy, educational therapy, physical fitness, or exercise programs, except as specifically stated in the Plan.

18. Fertilization methods (other than artificial insemination) including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT), and similar procedures and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

19. Follicle-stimulating hormone (FSH), activity medications, or ovulatory stimulant medications, including, but not limited to, Menotropins, Chorionic Gonadotropins, Urofollitropins and Clomiphene Citrate.

20. Health care services not specifically identified as being covered under the Plan.

21. Dental treatment, services, procedures, drugs, medicines, devices and supplies, except as specifically stated in the Plan.

22. Professional services not provided by a physician or any of the health care providers listed in the definition of Professional Services in the Plan.

23. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other non-operative partial removal of toenails; (c) in connection with any of those specified in (a) and (b). This exclusion does not apply to participants with a diagnosis of diabetes.

24. Abortion procedures for the termination of pregnancy, except as specifically stated in the Plan .

25. Health care services provided when a participant's coverage was not effective under the Plan. This includes health care services provided either prior to a participant's effective date of coverage or after his/her coverage terminated under the Plan, except as stated in the Plan .

26. Health education; marriage counseling; complimentary, alternative or holistic medicine; or other programs with an objective to provide complete personal fulfillment.

27. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in the Plan.

28. Health care services provided to or received by a participant as a collateral in connection with treatment of any person who is not a participant under this Plan.

29. Housekeeping, shopping, or meal preparation services.

30. Health care services provided during any waiting periods for pre-existing conditions, including any complications of such pre-existing conditions.

31. Food received on an outpatient basis, food supplements, or vitamins.

32. Diet pills (except as specifically stated in the Plan), diet injections, or diet therapy group meetings or visits. No benefits are payable for diet programs including, but not limited to, Weight Watchers, Weight Loss Clinic, Diet Workshop, Nutri-System, Weight Loss Center, The Diet Center, and other such programs.

33. Retin-A, Minoxidil, Rogaine, or their medical equivalent in the topical application form, unless medically necessary.

34. Health care services used in educational or vocational training or testing.

35. Health care services provided in connection with: (a) any illness or injury caused by a participant engaging in an illegal occupation; or (b) any illness or injury caused by a participant's commission of, or an attempt to commit, a felony.

36. Maintenance care or supportive care.

37. Room, board, services and supplies that are furnished to a participant by a hospital on the Friday and Saturday of the weekend of hospital admission if he/she is admitted as a registered resident patient to the hospital on one of those days, unless the participant's hospital admission is medically necessary or such admission is required to provide the participant with emergency medical care of a covered illness or injury.

38. Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in the Plan.

39. Oral surgical services, except as specifically stated in the Plan .

40. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.

41. Health care services provided in connection with a health care service not covered under the Plan. An example would be inpatient hospital services in connection with a health care service not covered under the Plan.

42. That portion of the amount billed for a health care service covered under the Plan that exceeds the Claim Administrator's determination of the charge for such health care service.

43. Health care services for which a participant has no obligation to pay.

44. Contraceptive devices, except as specifically stated in the Plan.

45. Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the Plan.

46. Health care services for which proof of claim isn't provided to the Claim Administrator as stated in the Plan.

47. Special shoes (other than diabetic shoes when such diabetic shoes are medically necessary) or devices, unless they are a permanent part of an orthopedic leg brace.

48. Health care services and prescription legend drugs provided in the connection with alcoholism, drug abuse and nervous or mental disorders, except as specifically stated in the Plan.

49. Health care services not for or related to an illness or injury, other than as specifically stated in the Plan.

50. Wigs, prosthetic hair pieces, hair transplants, or hair implants.

51. Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.

52. Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data.

53. Dental repair of a participant's sound natural teeth due to an accident caused by chewing resulting in damage to his/her sound natural teeth.

54. Maintenance therapy for chronic conditions.

55. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs, except as specifically stated in the Plan.

56. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of the participant's growth hormone deficiency.

57. Sleep therapy, or services provided in a premenstrual syndrome clinic or holistic medicine clinic.

58. Massage therapy.

59. Therapy and testing for treatment of allergies, including, but not limited to services related to clinical ecology, environmental allergy, allergic immune system dysregulation, sublingual antigen(s), RAST test, extracts, neutralization tests and/or treatment unless such therapy or testing is approved by The American Academy of Allergy and Immunology.

60. Treatment, services and supplies, including, but not limited to, surgical services, devices and drugs for, or used in connection with, sexual dysfunction, including, but not limited to, impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature, including, but not limited to, Viagra, Caverject, MUSE, Yohimbine, Femprox or their generic equivalent, penile implants and sex therapy.

61. Genetic testing, including, but not limited to any test using DNA to determine the presence of a genetic disease or disorder.

62. Telephone, computer or internet consultations between a participant and any health care provider, completion of claim forms or forms necessary for a participant's return to work or school or for an appointment a participant did not attend.

63. Smoking deterrents, such as, but not limited to, prescription legend drugs, patches, gum, hypnosis.

64. Health care services not supported by information contained in a participant's medical records from other relevant sources.

65. Cochlear implants, and all health care services provided in connection with cochlear implants.

66. Durable medical equipment or prosthetics that have special features.

67. Health care services provided by members of a participant's immediate family or anyone else living with him/her.

68. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials, except as specifically stated in s. 609.65, Wisconsin Statutes. Persons on work release are not considered to be held, detained or imprisoned if they are otherwise eligible participants.

69. Preparation, fitting or purchase of hearing aids and other internal or external hearing devices, including related services.

70. Health care services provided for a participant's convenience or for the convenience of a physician, hospital, or other health care provider.

COORDINATION OF BENEFITS

Applicability

1. This subsection applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.

2. If this subsection applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(a) shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(b) may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in paragraph 4. Effect on the Benefits of This Plan.

Definitions

Allowable Expense: a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

Claim Determination Period: a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or a similar provision takes effect.

Plan: any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include Medicare and Medicaid. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

3. Medical expense benefits coverage in group, group-type, and individual automobile “no-fault” contracts but, as to the traditional automobile “fault” contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under 1., 2. or 3. is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Primary Plan/Secondary Plan: the Order of Benefit Determination Rules states whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

This Plan: the part of the Plan that provides benefits for health care expenses.

Order of Benefit Determination Rules

1. General.

When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

(a) the other plan is automobile medical expense benefit coverage and has rules coordinating its benefits with those of this plan; and

(b) both those rules and this plan's rules described below require that this plan's benefits be determined before those of the other plan.

2. Rules.

This plan determines its order of benefits using the first of the following rules which applies:

(a) **Non-dependent/Dependent.** The benefits of the plan which covers the person as an employee, participant or subscriber are determined before those of the plan which covers the person as a dependent of an employee, participant or subscriber.

(b) **Dependent Child/Parents Not Separated or Divorced.** Except as stated in paragraph (c) below, when this plan and another plan cover the same child as a dependent of different persons, called “parents”:

(1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but

(2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

(c) **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the plan of the parent with custody of the child;

(2) then, the plan of the spouse of the parent with custody of the child; and

(3) finally, the plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to 2. b.

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

(d) **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (d) is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph (d).

(e) **Continuation Coverage.**

(1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits: (a) first, the benefits of a plan covering the person as an employee, participant or subscriber or as a dependent of an employee, participant or subscriber; (b) second, the benefits under the continuation coverage.

(2) If the other plan does not have the rule described in (1) above, and if, as a result, the plans do not agree on the order of benefits, this paragraph (e) is ignored.

(f) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, participant or subscriber longer are determined before those of the plan which covered that person for the shorter time.

Effect on the Benefits of This Plan

1. When This Paragraph Applies.

This paragraph applies when, in accordance with subsection "Order of Benefit Determination Rules", this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

(a) the benefits that would be payable for the allowable expenses under this plan in the absence of this section; and

(b) the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made. Under this provision, benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

Right to Receive and Release Needed Information

The Claim Administrator has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the participant but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give the Claim Administrator any facts it needs to pay benefits under the Plan.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, the Claim Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Claim Administrator will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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

2. insurance companies; or

3. other organizations.

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

TERMINATION OF INDIVIDUAL COVERAGE

All Participants

As determined by the Claim Administrator, a participant's coverage under the Plan shall end automatically without notice on the earliest of the following dates:

1. The date the Plan terminates;

2. The date a participant dies;

3. The day immediately following the last day of the calendar month for which the premium required for a participant's coverage has been paid to the Claim Administrator in accordance with the Plan;

4. The date a participant enters into military service, other than for duty of less than 30 days;

5. For a covered employee absent from work due to an illness or injury, the day immediately following the last day of the calendar month in which his/her status as an employee ends. However, if the covered employee is totally disabled and the Employer continues to pay the required contributions to continue the covered employee's coverage under the Plan, a covered employee's coverage will remain in force for no longer than six consecutive months following the date on which his/her coverage would have otherwise ended;

6. The day immediately following the last day of the calendar month in which a covered employee is not a full-time employee or is not within the class of employees eligible for coverage under the Plan. However, if the covered employee is temporarily laid-off, is working part-time, on an approved non-medical leave of absence and the Employer continues to pay the required contributions to continue the covered employee's coverage under the Plan, a covered employee's coverage will remain in force for no longer than three consecutive months following the date on which his/her coverage would have otherwise ended;

7. a covered employee's dependent who is a participant, the date the covered employee's coverage terminates.

Spouse

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants". Coverage shall also end on the date the covered employee's spouse is no longer married to the covered employee due to divorce or annulment;

Dependents

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants" and the following dates, as determined by the Claim Administrator:

1. The day immediately following the last day of the calendar month the child marries or acquires comparable group coverage as a covered employee;

2. The day immediately following the last day of the calendar year in which the child reaches age 19, if he/she is not a full-time student;

3. For full-time students, the earliest of the following dates:

a. The day immediately following the last day of the calendar month the child graduates, unless that child continues post-graduate schooling as a full-time student

b. for a child who completes a semester and who does not return to school as a full-time student the following semester, the day immediately following the last day of the calendar month preceding the following semester;

c. for a child who, due to illness or injury, is unable to continue full-time student status during a semester, the day immediately following the last day of the calendar month preceding the following semester;

d. The day immediately following the last day of the calendar month in which a full-time student attains age 25

4. The day immediately following the last day of the calendar month in which the child ceases to be an eligible dependent, as determined by the Claim Administrator;

5. The day immediately following the last day of the calendar month in which the child provides 50% or more of his/her own support, as determined by the Claim Administrator.

6. For a child of a dependent child who is a participant, the date the dependent child reaches age 18.

If a covered employee has family coverage under the Plan, a dependent child who is a mentally retarded or physically handicapped may continue coverage under his/her family coverage beyond the limiting age as set forth in subsection "Eligible Dependent".

Retirees

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants" and the following dates, as determined by the Claim Administrator:

1. The date the eligible retiree requests the termination of his/her coverage under the Plan.

2. The day immediately following the last day of the calendar month for which the premium required for a participant's coverage has been paid to the Claim Administrator in accordance with the Plan;

3. The day immediately following the date the eligible retiree dies. If the retiree dies, the spouse may continue coverage under the Plan for himself/herself and any covered dependents provided the spouse is eligible for pension continuation. The spouse's coverage will continue until the spouse elects to terminate his/her coverage, the spouse's coverage is terminated for nonpayment of premium, or the spouse dies. Covered dependents' coverage shall end as stated in J. above or when the spouse's coverage terminates, whichever is earlier.

CONTINUATION COVERAGE PRIVILEGE

The employee or a family member has the responsibility to inform the Employer within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan in order to be eligible for COBRA continuation as stated in this section.

All participants covered under the Plan who would otherwise lose coverage as the result of a “qualifying event” have the right to elect continued health care coverage.

A qualifying event is any one of the following events which, but for continuation of coverage, would result in the loss of health insurance coverage:

1. the death of the covered employee;

2. the termination of the covered employee (other than by the employee's gross misconduct);

3. a reduction in a covered employee's hours of employment;

4. the divorce or annulment of the covered employee from the employee's spouse;

5. the covered employee's becoming entitled to Medicare coverage; or

6. the cessation of dependent child coverage under the terms of the Plan (for example, upon the employee's child attaining the limiting age of the Plan).

No employee, spouse or child will be considered a participant unless, on the date before the qualifying event, that individual was covered under the Plan.

Within 14 days of the Employer receiving notice to end coverage, the Employer must notify the participant of:

1. His/her option to continue or convert his/her coverage;

2. The amount the participant must pay monthly to continue his/her coverage under the Plan. The amount for continued coverage under the Plan will be the rate required for others in the Plan;

3. The manner in which and the place to which the participant must make premium payment; and

4. The time by which the participant must pay for continued coverage.

A participant must elect continuation coverage during the 60 day period (1) beginning on the date coverage would otherwise terminate due to a qualifying event or (2) beginning on the date the participant receives notice of his/her continuation rights.

If the participant elects to continue coverage within the 60 day period, the continuation coverage must be effective as of the date of the qualifying event. A participant who elects coverage will be charged with the cost of the coverage during the 60 day period.

The initial coverage premium must be received within 45 days of enrolling. Thereafter, premium payments are due in advance and payable no later than the last day of each month.

If a participant fails to apply for coverage within the 60 day period described above, or he/she fails to send his/her first premium payment within 45 days of enrolling, he/she will forfeit his/her right to coverage under the Plan.

If a covered employee who elects continuation coverage wishes to change to family coverage to add his/her newborn natural child or adopted child, he/she must apply within 30 days of the birth, adoption or placement for adoption. The effective date for such family coverage will be the date of that child's birth, adoption or placement for adoption.

The duration of continuation coverage which begins on the date of the qualifying event is as follows:

1. For spouses of deceased employees, divorced spouses, spouses of Medicare eligible employees and dependent children who would otherwise become ineligible for coverage under the Plan, continuation coverage will be provided for 36 months.

2. For terminated employees and employees with reduced hours, continuation coverage will be provided for 18 months. If an employee or his/her spouse or dependent children who are covered under the Plan are disabled as defined by Social Security at the time of termination of employment or the reduction in hours which triggered the qualifying event or during the first 60 days of continuation coverage, coverage will be provided for an additional extension of 11 months at an increased premium, but only if the employee, spouse or dependent notifies the Employer within 60 days of the date of the Social Security disability determination.

However, if one of the following events occurs before the expiration of the 18 or 36 months period, coverage will end at that time:

1. the termination of the Plan;

2. the failure to make timely premium payments under the Plan;

3. the participant becomes covered under another group health plan as a result of employment, reemployment, or remarriage;

4. the participant becomes entitled to Medicare benefits; or

5. the participant becomes covered under another group health plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of the participant.

ADDITIONAL PROVISIONS

Proof of Claim

A participant, or the physician, hospital or other health care provider on the participant's behalf, must submit written proof of his/her claim for each treatment, service or supply provided to him/her to the Claim Administrator within 120 days of the date on which he/she receives that treatment, service or supply. Written proof of his/her claim includes: (1) the completed claim forms if required by the Claim Administrator; (2) the actual itemized bill for each treatment, service or supply; and (3) all other information that the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan, including, but not limited to, medical records and reports. Circumstances beyond a participant's control might prevent him/her from submitted such proof to the Claim Administrator within this time period. If so, he/she must file written proof of his/her claim with the Claim Administrator as soon as possible; but it can't be later than one year and 120 days after such treatment, service or supply was provided to him/her, unless the participant is legally incapacitated as determined by a court of law during this entire period. If the Claim Administrator doesn't receive the written proof of claim required by the Claim Administrator within that one-year and 120-day period and the participant is not legally incapacitated, no benefits are payable for that treatment, service or supply under the Plan.

Physician, Hospital or Other Health Care Provider Reports

Physicians, hospitals and other health care providers must give the Claim Administrator their records and reports to help the Claim Administrator determine benefits due to a participant. By accepting coverage under the Plan the covered employee agrees to authorize his/her physicians, hospitals and other health care

providers to release all medical records and reports to the Claim Administrator for himself/herself and all his/her dependents. This is a condition of the Plan providing coverage to the covered employee and all his/her dependents. It's also a continuing condition of the Plan paying benefits. The covered employee expressly authorizes and directs the following to release these records and reports to the Claim Administrator: (1) any physician who has diagnosed for, attended, treated, advised or provided professional services to a participant; (2) any hospital in which that participant was treated or diagnosed; and (3) any other health care provider who has diagnosed for, attended, treated, advised or provided treatment, services or supplies to a participant. The covered employee authorizes them to furnish to the Claim Administrator any and all information related to the treatment, services, supplies or facilities provided to or used by a participant, to the extent required by a particular situation and allowed by applicable law. The covered employee also expressly authorizes the Claim Administrator to release to or obtain from any other insurance company or service or benefit plan the information which the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan.

Assignment of Benefits

This coverage is just for the covered employee and his/her dependents. Benefits may be assigned to the extent allowed by applicable laws and regulations.

Limitation on Lawsuits and Legal Proceedings

No participant shall bring any legal action against the Employer and/or the Claim Administrator regarding benefits, claims submitted, to compel payment of benefits or any other matter concerning the participant's coverage under the Plan until the earlier of: (1) 60 days after the Claim Administrator has received or waived proof of claim described in subsection “Proof of Claim”; or (2) the date the Claim Administrator denies payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a participant. However, the mere fact that a participant has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time the Claim Administrator requires written proof of claim.

Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the Plan, the Claim Administrator has the option of paying benefits either directly to the physician, hospital or other health care provider, or to the covered employee as described in subsection “Claims Processing Procedure”. Payments for covered expenses for which the Employer is liable may be paid under another group or franchise plan or policy arranged through the covered employee's employer, trustee, union or association. If so, the Claim Administrator can discharge the Employer's liability by paying the organization that has made these payments. In either case, such payments shall fully discharge the Employer from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If the Claim Administrator pays more benefits than what the Employer is liable to pay for under the Plan, including, but not limited to, benefits paid in error by the Claim Administrator, the Claim Administrator can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. The Claim Administrator can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If the Claim Administrator cannot recover such excess benefit payments from any other source, it can also recover such excess benefits payments from a covered employee. When the Claim Administrator

requests that the covered employee pay the Claim Administrator an amount of the excess benefit payments, the covered employee agrees to pay the Claim Administrator such amount immediately upon the Claim Administrator's notification to the covered employee. The Claim Administrator may, at its option, reduce any future benefit payments for which the Employer is liable under the Plan on other claims by the amount of the excess benefit payments, in order to recover such payments. The Claim Administrator will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by the Claim Administrator.

Subrogation

1. Right to First Reimbursement and First Recovery.

When the Plan advances benefits to, or on behalf of, any participant because of a disability or loss which may have been caused by another person, corporation, or any other entity, or which is covered by any other insurance policy, benefit plan, fund or self-funded plan, the Plan shall have the following rights to recover 100% of the benefits advanced to, or on the behalf of, the participant, in addition to any other rights available to the Plan under applicable law:

a. A right of first reimbursement from, and an automatic first lien upon, any judgment, settlement or other amount payable to, or on behalf of, the participant or the participant's estate on account of the disability or loss, regardless of the source of the funds or the sufficiency or the allocation of the amount payable and with first priority over any other payouts demanded or claims asserted by any other party. The proceeds of any judgment, settlement or other amount subject to this provision shall be held in trust for the benefit of the Plan; and

b. A right of first recovery from and against any insurance company, corporation, or other entity which has insured or covers the participant against damages, costs, or expenses arising from the disability or loss sustained by the participant, including, but not limited to, uninsured motorist insurance coverage, underinsured motorist coverage, "no-fault" insurance coverage, any applicable umbrella insurance coverage, or medical payments coverage under any type of insurance coverage; and

c. A right of first recovery from and against any person, corporation or other entity who or which is or may be liable or responsible for the disability or loss.

2. Assignment of Claims and Pursuit of Recovery and Reimbursement

By accepting coverage under the Plan, each participant hereby assigns irrevocably and forever to the Plan all of that participant's rights, claims and causes of action as outlined above to the extent of all benefits advanced. In turn, the Plan hereby assigns all of its rights of recovery and reimbursement, including, but not limited to, the assigned rights, claims, and causes of action of the participant to the Claim Administrator

No settlement, compromise or waiver of any rights, claims, or causes of action by any participant or his/her attorney, agent or representative shall be entered into without that person first obtaining the Claim Administrator's written consent. The participant agrees not to do anything that prejudices, hinders, adversely affects, or changes any of the Plan's and Claim Administrator's rights under this provision. Entering into any such settlement, compromise, or waiver by the participant or his/her attorney, agent, or representative is a breach of the Plan; such breach shall be deemed to prejudice the Plan's and Claim Administrator's rights under this provision.

The Claim Administrator has the option to take all reasonable action to protect its rights, including, but not limited to, bringing a lawsuit or other legal action in the participant's name, the Plan's name or its name against any person, corporation or other entity who or which is or may be liable or

responsible for the disability or loss. The Plan or Claim Administrator is entitled to recover its attorneys' fees, court costs and any other costs or expenses of recovery or collection which may be incurred by the Plan or Claim Administrator in obtaining or securing the recovery or reimbursement from any proceeds received by, or under the control of, the participant or their attorney, agent, or representative.

Neither the Plan nor the Claim Administrator shall be liable or responsible for nor shall their recovery or reimbursement be reduced or diminished under any circumstances by attorneys' fees, court costs, or any other costs or expenses of recovery or collection which may be incurred by the participant, or any other person, corporation, or other entity representing the participant or acting on their behalf.

The participant shall promptly advise the Plan and Claim Administrator in writing whenever a right, claim, or cause of action is asserted or made against any person, corporation, or other entity by, or on behalf of, that participant. The participant or his/her attorney, agent, or representative shall provide the Plan and Claim Administrator with any information requested by the Plan or Claim Administrator. The participant shall execute any documents and do whatever else the Plan or Claim Administrator shall reasonably require in order for the Plan and Claim Administrator to obtain recovery or reimbursement and not be prejudiced in exercising the foregoing rights set forth in this provision. The participant agrees to, and shall, cooperate fully with the Plan and the Claim Administrator at every stage, including, but not limited to, claims investigation, recovery efforts, and court or administrative proceedings.

Claims Processing Procedure

1. Definitions.

Correctly filed claim: a claim that includes: (a) the completed claim forms if required by the Claim Administrator; (b) the actual itemized bill for each health care service; and (c) all other information that the Claim Administrator needs to determine the Plan's liability to pay benefits, including but not limited to, medical records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, or subrogation questionnaire.

Incorrectly filed claim: claim that is filed that lack information which enables the Claim Administrator to determine what, if any, benefits are payable under the terms and conditions of the Plan. Examples would include, but are not limited to, claims filed that are missing procedure codes, diagnosis or dates of service.

2. Procedures.

Benefits payable under the Plan will be paid after receipt of a correctly filed claim or utilization review request. The Claim Administrator will notify a participant of its decision on the participant's claim as follows:

a. Concurrent Care. Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for a participant to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a benefit change or termination of the Plan.

Request to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if a participant's condition requires a shorter time

frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

b. **Pre-Service Claims.** A pre-service claim is any claim for a benefit under the Plan which requires prior approval or precertification before obtaining medical care. For prescription legend drugs, submission of a prescription to a pharmacy or pharmacist will not constitute a claim for benefits under the terms and conditions of the Plan. Claims made after 4:00 PM will be logged in and handled on the next business day.

(1) **Urgent Pre-Service Claims.** Within 72 hours of receipt of an urgent pre-service claim or as soon as possible if a participant's condition requires a shorter time frame. Such claim maybe submitted by telephone, electronic facsimile (i.e. fax) or mail. An urgent pre-service claim is a claim for services for emergency medical care as defined in the Plan.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator will notify the participant of the specific information needed with 24 hours. The participant will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of the Claim Administrator's receipt of the additional information, the Claim Administrator will give its decision on the claim. If the participant fails to provide the information requested by the Claim Administrator, the Claim Administrator will provide the participant with its decision on the claim based on the most current information that the Claim Administrator has within 48 hours of the end of the period that the participant was given to provide the information.

If the participant fails to follow this procedure for prior approval or precertification requests, the Claim Administrator will notify him/her within 24 hours of the Claim Administrator's receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

(2) **Non-Urgent Pre-Service Claims.** Within 15 days of receipt of a non-urgent pre-service claim.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator will notify the participant of a 15 day extension and the specific information needed. The participant will then have 45 days from the receipt of the notice to provide the requested information. Once the Claim Administrator receives the additional information, the Claim Administrator will make its decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 15-day period. For example, if the Claim Administrator>s notification was sent to the participant on the fifth day of the first 15-day period, the Claim Administrator would have a total of 25 days to make a decision on the participant's claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on the participant's claim exceed 75 days from the date the Claim Administrator received the non-urgent pre-service claim.

If the participants fails to follow the Plan's procedure for prior approval or precertification requests, the Claim Administrator will notify the participant within five days of the Claim Administrator's receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or pre-authorization.

c. Post-Service Claims. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim within 30 days of receipt of the claim.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator may notify the participant of a 15 day extension and the specific information needed. The participant will then have 45 days from the receipt of the notice to provide the requested information. Once the Claim Administrator receives the additional information, the Claim Administrator will make its decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if the notification was sent to the participant on the fifth day of the first 30-day period, the Claim Administrator would have a total of 40 days to make a decision on the participant's claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on the participant's claim exceed 90 days from the date the Claim Administrator received the post-service claim.

If benefits are payable on charges for services covered under the Plan, payment of such benefits shall be made directly to the hospital, physician or other provider providing such services, unless a participant has paid the charges and submitted paid receipts therefor to the Claim Administrator before benefits are paid. The Claim Administrator will send the participant written notice of the benefits paid on his/her behalf. If a participant paid the charges and is seeking reimbursement, payment of such benefits will be made directly to the participant.

If the claim is denied in whole or in part, the participant will receive a written notice from the Claim Administrator with (1) the specific reasons for denial or partial denial is based; (2) the specific references to the Plan provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary for the participant to perfect his/her claim and an explanation of why such material or information is necessary; and (4) an explanation of how the participant may have the claim reviewed by the Claim Administrator if he/she does not agree with the denial or partial denial.

Claim Appeal Procedure

A participant may appeal the denial of a claim or utilization review decision by following these procedures:

1. File a written request with the Claim Administrator for a full and fair review of the claim by the Plan;

2. Request to review documents pertinent to the administration of the Plan; and

3. Submit written comments and issues outlining the basis of his/her appeal.

A request for a review must be filed with the Claim Administrator within 180 days after receipt of the claim denial. If the participant's request for review is not received within 180 days, his/her right to appeal the claim denial is forfeited.

If the participant's request for review is received within 180 days. a full and fair review of the claim will be held by the Claim Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medically necessary, a medical consultant that has the appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a health care service, a medical consultant that has the appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed.

After the review, the decision will be made to the participant in writing. It will include the specific reasons for the decision as well as the specific references to the Plan provisions on which the decision is based. The participant will be notified of the Plan decision as follows:

1. For urgent care claims, within 72 hours or as soon as possible if the participant's condition requires a shorter time frame;

2. For pre-service claims, within 30 days or as soon as possible if the participant's condition requires a shorter time frame; or

3. For post-service claims, within 60 days.

An expedited appeal process is available for urgent care cases.

The participant may have representation during the review process.

Coverage with Medicare

1. **Carve-Out.** This paragraph 1. applies only to eligible retirees.

If covered charges are incurred by a participant who is eligible to apply for Medicare, the Claim Administrator will determine the benefits, if any, payable for those charges for health care services covered under the Plan using the Medicare "Carve-Out" method. A participant who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare. For example, if a participant is eligible to enroll in Medicare Part B, but fails to do so, or terminates his/her Medicare Part B coverage, the Claim Administrator will still determine the benefits payable under the Plan as if that participant had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits.

When using this method, benefits will be determined by the Claim Administrator as follows:

a. On the total charge of a health care service, the Claim Administrator will determine the benefits payable under the Plan, subject to any applicable deductible, coinsurance and copay amounts, and all other terms, conditions and provisions of the Plan.

b. Determine a participant's responsibility for payment due on the same charge after applicable Medicare payment.

c. Payment on that charge will be the lesser of the amount of benefit determined under paragraph a. and the amount determined in paragraph b.

This Medicare "Carve Out" method of computing benefits for participants eligible for Medicare shall apply unless federal law requires that benefits be computed according to the "Medicare as Secondary Payer" rules set forth in 2. below or the Employer submits written proof in a form satisfactory to the Claim Administrator that federal law requires greater benefits be paid under the Plan. In such event, the Claim Administrator shall pay the additional benefits required by that federal law.

When using this method, participants may be responsible for any applicable deductible, copayment and coinsurance amounts. For a more detailed explanation of how this method works, please see the General Information section of your member guide.

2. Medicare as Secondary Payer.

If covered charges are incurred by a participant who is a Medicare beneficiary, the Claim Administrator will determine the benefits payable under the Plan using the following rules. The rules require Medicare to pay as secondary (and the employer group health plan as primary) when:

a. The covered participant (employee or the employee's spouse) is age 65 or older and is covered under an employer group health plan of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding calendar year and has not elected to have Medicare as the sole source of medical protection.

b. The covered participant is under age 65, is covered under an employer group health plan of an employer of at least 100 employees, as a result of the participant's current employment status or that of a covered family member, and is receiving Medicare benefits due to a permanent and total disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding calendar year.

A person with "current employment status" is an individual who is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship.

c. A participant is covered under an employer group health plan, and has end-stage renal disease (ESRD). If an ESRD patient has health insurance coverage under an employer group health plan, Medicare is secondary for 30 months from entitlement to, or eligibility for, Medicare Part A based on ESRD.

Right of Reimbursement - Work Related Injury or Illness

If benefits are paid under the Plan and the Claim Administrator determines that a participant received Worker's Compensation benefits of any kind whether by settlement, judgment or otherwise for the same incident, the Claim Administrator has a right to recover from the participant an amount equal to the amount the Claim Administrator paid. This right of reimbursement will be applied 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 illness was sustained in the course of or resulted from a participant's employment;

3. the amount of Worker's Compensation due to medical or health care is not agreed upon or defined by the participant or the Worker's Compensation carrier; or

4. the medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

The covered employee hereby agrees that, in consideration for the coverage provided by the Plan, he/she will notify us of any Worker's Compensation claim he/she makes, and that he/she agrees to reimburse us as described.

If you have any questions on the information contained in this booklet, please do not hesitate to contact:

WPS Administrative Services
1717 West Broadway
P.O. Box 8190
Madison, Wisconsin 53708

Phone: Please call the number shown on your Plan Identification Card
Website: www.wpsic.com

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