



**Claims
Administrator:
Midwest Security**

WCA GROUP HEALTH TRUST
COOPERATIVE EDUCATIONAL SERVICES AGENCY
(CESA #8)

EMPLOYEE MEDICAL PLAN

GROUP NUMBER: WCA0083

Underwritten By:
WCA Group Health Trust
22 East Mifflin Street Suite 900
Madison, Wisconsin
(866) 404-2700 (toll-free)

Effective Date: July 1, 2007

Authorized Representative (Group)

**Authorized Representative,
WCA Group Health Trust**

Title

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Date

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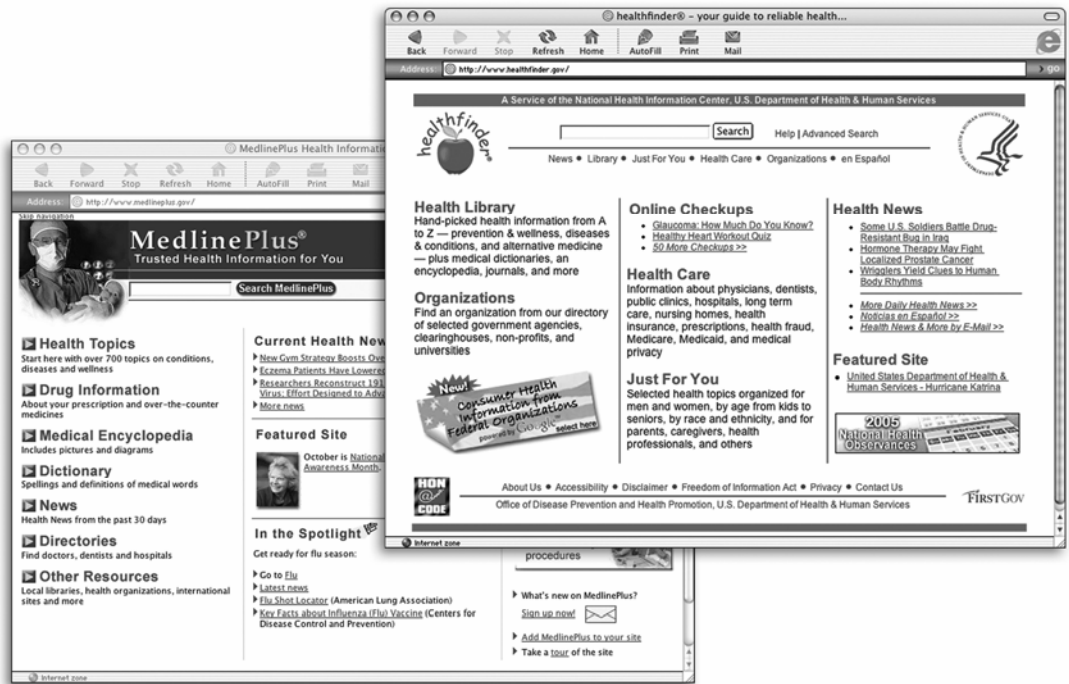


TABLE OF CONTENTS

SECTION 1 MEDICAL BENEFITS

PAYMENT OF COVERED EXPENSES	1-1
AN IMPORTANT MESSAGE ABOUT YOUR PLAN	1-2
CERTIFICATION PROCEDURES	1-2
SECOND SURGICAL OPINION	1-2
MEDICAL BILL REVIEW	1-2
SCHEDULE OF BENEFITS	1-3
MEDICAL BILL REVIEW	1-3
MEDICAL BENEFITS	1-3
MEDICAL BENEFITS	1-13
DEDUCTIBLE AND COINSURANCE INFORMATION	1-13
MEDICAL COVERED EXPENSES	1-14
INPATIENT HOSPITAL BENEFITS	1-14
QUALIFIED PRACTITIONER BENEFITS	1-14
WELLNESS BENEFIT	1-15
ROUTINE MAMMOGRAMS	1-16
DIAGNOSTIC AND MEDICALLY NECESSARY MAMMOGRAMS	1-16
ROUTINE PAP SMEARS	1-16
ROUTINE PROSTATE TESTS	1-16
OUTPATIENT HOSPITAL BENEFITS	1-16
AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY	1-17
X-RAY AND LABORATORY TESTS	1-17
AMBULANCE SERVICE BENEFIT	1-17
PREGNANCY BENEFIT	1-17
NEWBORN BENEFITS	1-18
BIRTHING CENTER BENEFIT	1-18
HOME HEALTH CARE BENEFIT	1-18
CONVALESCENT NURSING HOME BENEFIT	1-19
HOSPICE CARE BENEFIT	1-19
HOSPICE CARE BENEFIT - CONTINUED	1-20
HUMAN ORGAN AND TISSUE TRANSPLANTS	1-20
PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT	1-22
OTHER COVERED EXPENSES	1-24
LIMITATIONS AND EXCLUSIONS	1-28
ALTERNATIVE TREATMENTS	1-28
DENTAL	1-28
DRUGS	1-28
EXPERIMENTAL OR UNPROVEN SERVICES	1-28
PHYSICAL APPEARANCE	1-29
PRE-EXISTING CONDITIONS	1-29

PROVIDERS	1-29
REPRODUCTION	1-30
ROUTINE AND GENERAL HEALTH	1-30
SERVICES UNDER ANOTHER PLAN	1-31
OTHER	1-31

PRESCRIPTION DRUG CARD 1-33

SECTION 2 DEFINITIONS

DEFINITIONS	2-1
--------------------	------------

SECTION 3 ELIGIBILITY

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE 3-1

EMPLOYEE ELIGIBILITY	3-1
DEPENDENT ELIGIBILITY	3-1
DEPENDENT EFFECTIVE DATE	3-2
SPECIAL ENROLLMENT RIGHTS	3-2
BENEFIT CHANGES	3-3
REINSTATEMENT OF COVERAGE	3-3
TERMINATION OF COVERAGE	3-4
EXTENSION OF MEDICAL BENEFITS – INDIVIDUAL TERMINATION	3-5
EXTENSION OF MEDICAL BENEFITS – GROUP TERMINATION	3-5

FAMILY AND MEDICAL LEAVE ACT (FMLA) 3-6

EMPLOYEE ELIGIBILITY	3-6
FAMILY AND MEDICAL LEAVES	3-6
REINSTATEMENT OF COVERAGE UPON RETURN TO WORK	3-7
DEFINITIONS	3-7

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) 3-9

CONTINUATION OF COVERAGE DURING MILITARY LEAVE	3-9
REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE	3-10

CONTINUATION AND CONVERSION OF BENEFITS 3-11

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)	3-11
INDIVIDUAL CONVERSION PLAN	3-15

SECTION 4 GENERAL PLAN INFORMATION

COORDINATION OF BENEFITS	4-1
---------------------------------	------------

RECOVERY RIGHTS	4-4
GENERAL RECOVERY RIGHTS PROVISIONS	4-4
GENERAL PROVISIONS	4-6
ALTERNATE RECIPIENTS	4-6
AMENDMENTS TO OR TERMINATION OF THE PLAN	4-6
ASSIGNMENT	4-6
CLAIM REVIEW PROCEDURE	4-6
CLERICAL ERROR	4-7
CONFORMITY WITH APPLICABLE LAWS	4-7
CONTRIBUTIONS TO THE PLAN	4-7
COOPERATION	4-7
FAILURE TO ENFORCE PLAN PROVISIONS	4-7
FREE CHOICE OF PROVIDER	4-7
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT	4-7
LEGAL ACTIONS	4-7
PAYMENT OF CLAIMS	4-8
PHYSICAL EXAMINATION	4-8
PRIVACY OF PROTECTED HEALTH INFORMATION	4-8
PROOF OF LOSS	4-11
PROTECTION AGAINST CREDITORS	4-11
REPRESENTATIONS	4-11
SECURITY	4-11
TERMINATION OF THE PLAN	4-12
TIME OF PAYMENT OF CLAIMS	4-12

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SECTION 1 MEDICAL BENEFITS

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PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan for the benefits selected by the Covered Employee, subject to deductibles, copayments, maximums, and all other terms, provisions, limitations, conditions and exclusions of the Plan. Capitalized words and phrases are defined in Section 2 - Definitions.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

CERTIFICATION PROCEDURES

Managed Care Concepts (MCC) will handle the certification requirements of Your Plan. You should call as soon as possible to receive proper Certification. The MCC toll-free number is on the back of Your ID card. For additional information, call MCC.

Non-Emergency Admissions: You should notify MCC at least 48 hours in advance of any Non-Emergency Qualified Treatment Facility admission. No penalty will be applied if You do not notify MCC.

Emergency Admissions: You should notify MCC within 48 hours or on the first business day after Your admission. No penalty will be applied if You do not notify MCC.

Inpatient stays resulting from the birth of a child do not need to be certified unless the stay, for mother or child, exceeds 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery. Admissions which exceed these time limits must be certified by MCC as stated above.

Certification by MCC is not a guarantee of coverage.

SECOND SURGICAL OPINION

Charges for a second opinion, including any related x-rays and laboratory tests, will be payable, subject to the deductible and coinsurance. You may go to a Qualified Practitioner of Your choice, provided that the Qualified Practitioner is not affiliated with the Qualified Practitioner rendering the initial recommendation and does not perform the procedure in question. Charges for a third opinion will also be payable, subject to the deductible and coinsurance, provided the Qualified Practitioner offering the third opinion is not affiliated with the Qualified Practitioner rendering the initial and second recommendations and does not perform the procedure in question.

MEDICAL BILL REVIEW

You should carefully review Your bill for any service. If You find any errors such as:

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bill, with the errors circled, and the corrected bill to the Claim Administrator. This serves as proof that the provider of service agreed to the corrections. **If You are correct, You will receive 50% of the errors in the bill, but not more than \$500 paid per bill.**

SCHEDULE OF BENEFITS

MEDICAL BILL REVIEW

If You discover a billing error, report it to the Plan. As a reward, You will receive 50% of the error, but not more than **\$500 paid per bill**.

MEDICAL BENEFITS

Plan Lifetime Maximum: \$2,000,000 per Covered Person.

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
<p>Deductible per Calendar Year</p> <p>PPO</p> <p>Individual \$0 \$250</p> <p>Employee + Spouse \$0 \$500</p> <p>Employee + 1 Child \$0 \$500</p> <p>Family \$0 \$750</p> <p>Non-PPO</p> <p>Individual \$0 \$250</p> <p>Employee + Spouse \$0 \$500</p> <p>Employee + 1 Child \$0 \$500</p> <p>Family \$0 \$750</p>			<p>The amount You must pay each year before the Plan will begin paying any benefits.</p> <p>PPO and Non-PPO maximums are on an aggregate dollar basis.</p> <p>Calendar Year means January 1 to December 31.</p>	1-13
<p>Coinsurance per Calendar Year</p> <p>PPO 100% 0%</p> <p>Non-PPO 80% 20%</p>			<p>After the deductible, the coinsurance amounts shown in this section will apply until the Calendar Year out-of-pocket limits are met. After which the Plan pays 100% of Covered Expenses, subject to any maximums, for the rest of that Calendar Year.</p> <p>Calendar Year means January 1 to December 31.</p>	1-13

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
<p>Out-of-Pocket Limit per Calendar Year</p> <p>PPO</p> <p>Individual \$250 Employee + Spouse \$500 Employee + 1 Child \$500 Family \$750</p> <p>Non-PPO</p> <p>Individual \$750 Employee + Spouse \$1,500 Employee + 1 Child \$1,500 Family \$1,750</p>			<p>Represents the total paid by You for the deductible and coinsurance. After which the Plan pays 100% of Covered Expenses, subject to any maximums, for the rest of that Calendar Year.</p> <p>PPO and Non-PPO maximums are on an aggregate dollar basis.</p> <p>Your out-of-pocket expense for a Calendar Year will never exceed the Non-PPO out-of-pocket limit.</p> <p>Calendar Year means January 1 to December 31.</p>	1-13
Pre-Existing Conditions	0%	100%	Benefits for conditions existing prior to Your Enrollment Date may be limited during Your first 12 months (18 months for a Late Applicant) of coverage.	1-29

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
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All Covered Expenses under the Plan are payable at the Plan’s Customary, Usual and Reasonable limits. The deductible and coinsurance limits shown above apply to all Covered Expenses unless stated otherwise below.

PPO Benefit Provision

PPO Benefits will be payable for Non-PPO provider services **only** if:

1. You *live*, or are attending a college that is located, outside of the PPO service area.
2. The required medical services are not available from a PPO provider.
3. Your condition requires emergency medical care.
4. You receive treatment that is a Covered Expense from a PPO provider and as a result of that treatment, a Covered Expense is incurred from a Non-PPO provider. Such Non-PPO services must be performed without Your knowledge or choice.
5. A PPO provider refers You to a Non-PPO provider to receive treatment that is not available from a PPO provider. This provision will apply when, in the opinion of Your Qualified Practitioner, there is **no choice** or **alternative means of treatment** available.
6. You receive treatment that is a Covered Expense from a PPO provider and as a result of that treatment, a Covered Expense is incurred from a Non-PPO provider that is a pathologist; anesthesiologist; cardiologist; radiologist; or emergency room physician.

Continuity of Care: If You are undergoing a covered course of treatment from a PPO provider and that provider terminates from the PPO network during Your course of treatment, Covered Expenses that You incur from that provider for such course of treatment will continue to be paid as PPO. Refer to the “Medical Benefits” page of this Plan (after the Schedule of Benefits) for details.

Schedule of Benefits – continued

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Semi-private room and board, intensive care or coronary care.	1-14
Qualified Practitioner Office Services Benefit	PPO: \$20 copay per visit, then 100% Non-PPO: Deductible/80% to coinsurance limit	<i>PPO:</i> This copay does not apply to the out-of-pocket limits. Benefits include office visits and other <i>covered expenses</i> performed in the office on the same date of service, whether an office visit is billed with that service or not. This copay will apply to all <i>covered expenses</i> listed below, if performed in an office, unless the benefit specifically states that it does not apply. Deductible and coinsurance are waived for this benefit. Allergy Testing and Allergy Injections are included under this benefit.	1-14
Qualified Practitioner Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Inpatient and outpatient Hospital visits, surgery and anesthesia.	1-14
Oral Surgery Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Refer to list of covered oral surgeries in text. The Office Visit copay does not apply to this benefit.	1-15

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	<p>PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: 80%, deductible waived, to the Non-PPO to coinsurance limit</p> <p>Immunizations Up To Age Six Years: Payable under a separate benefit, as shown under the Other Covered Expenses.</p>	<p>Covers routine exams and check-ups, well child care, immunizations and vaccinations for a Covered Person age six years and older (refer to text for list), x-rays and lab tests, routine hearing tests, screening colonoscopy and flexible sigmoidoscopy, bone density screening, nutritional counseling visits, routine exams for school, sports, camps, scouting and other activities that require a pre-participation exam.</p> <p>All covered lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p> <p>Note: <u>Subject to the limits shown in the text.</u></p> <p>Routine Mammograms, Pap Smears, Prostate Tests & Vision Exams: Payable under separate benefits.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-15
Routine Mammograms	<p>PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: 100%, deductible and coinsurance waived</p>	<p>Limited to one routine mammogram per Calendar Year.</p> <p>The Office Visit copay does not apply to this benefit.</p> <p>Diagnostic and Medically Necessary mammograms are payable under a separate benefit, as shown below.</p>	1-16
Diagnostic and Medically Necessary Mammograms	<p>PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Deductible/80% to the Non-PPO coinsurance limit</p>	<p>Routine mammograms are payable under a separate benefit, as shown above.</p>	1-16

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Routine Pap Smears	<p>PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: 100%, deductible and coinsurance waived</p>		1-16
Routine Prostate Tests	<p>PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: 100%, deductible and coinsurance waived</p>		1-16
Outpatient Hospital Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-16
Emergency Room Benefit	<p>PPO: \$100 copay per visit, then 100% (deductible waived)</p> <p>Non-PPO: \$200 copay per visit, then 100% (deductible waived)</p>	<p>This copay does not apply to the out-of-pocket limit. The deductible and coinsurance are waived for this benefit.</p> <p>This copay is waived if You are admitted to the Hospital from the Emergency room visit.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room on the same date of service.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-16
Urgent Care/ Walk-In Clinic	<p>PPO: \$50 copay per visit, then 100%</p> <p>Non-PPO: \$50 copay per visit, then deductible/80% to coinsurance limit</p>	<p>PPO: This copay does not apply to the out-of-pocket limits. The deductible and coinsurance are waived for this benefit.</p> <p>Non-PPO: This copay does not apply to the out-of-pocket limit.</p> <p>Includes all related Covered Expenses billed with the same date of service.</p>	1-16

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Ambulatory Surgical Center	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-17
X-ray and Laboratory Tests	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	<p>Dental x-rays limited to covered oral surgery or Injury.</p> <p><u>In The Office:</u> X-ray and lab tests performed in a Qualified Practitioner's office are payable as shown above in the Qualified Practitioner Office Services benefit.</p> <p>All covered lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-17
Ambulance Service Benefit	PPO Deductible/ 100% to the PPO coinsurance limit (for PPO and Non-PPO)	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.	1-17
Pregnancy Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Covered for Employee, spouse and Dependent daughter.	1-17
Newborn Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	See "Section 3 – Eligibility" for important information on Dependent Coverage.	1-18
Birthing Center Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-18
Home Health Care Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	40 visits per Calendar Year, when Home Health Care is in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home.	1-18

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Convalescent Nursing Home Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Limited to 30 days per Confinement.	1-19
Hospice Care Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Hospice Care must be in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home.	1-19
Human Organ and Tissue Transplants	<i>PPO</i> : Deductible/ 100% to coinsurance limit <i>Non-PPO</i> : Not Covered	Special Transplant Network Benefits: Payable only if You use a transplant network provider. Benefits for travel expenses and lodging are limited to a <u>maximum of \$10,000</u> paid per transplant. Refer to the text for details. Refer to list of covered transplants in text	1-20
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	<i>PPO</i> : 100%, deductible and coinsurance waived <i>Non-PPO</i> : 90%, deductible waived	Inpatient: 10 days per Calendar Year Transitional: 20 days per Calendar Year Outpatient: 30 visits per Calendar Year. One day of inpatient will reduce the transitional benefit by two days. Two days of transitional will reduce the inpatient benefit by one day. The Office Visit copay does not apply to this benefit.	1-22
Other Covered Expenses	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-24
Chiropractic Care	<i>PPO</i> : \$20 copay per visit, then 100% <i>Non-PPO</i> : Deductible/80% to coinsurance limit	<i>PPO</i> : This copay does not apply to the out-of-pocket limit. The deductible and coinsurance are waived for this benefit. Routine and maintenance care is not covered.	1-24

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Physical, Speech, Occupational and Respiratory Therapy	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	The Office Visit copay does not apply to this benefit.	1-24
Cardiac Rehabilitation	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Limited to Phase I and Phase II only. Phase II: Must begin within 30 days after discharge from the hospital.	1-24
TMJ Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit.	Covers surgical, non-surgical and diagnostic treatment. Diagnostic & Non-Surgical Treatment: Limited to a combined maximum of \$1250 paid per Calendar Year.	1-25
Blood Lead Tests (State Mandate)	PPO: 100%, deductible waived Non-PPO: 80%, deductible waived, to the Non-PPO to coinsurance limit	For covered Dependent children under the age of six years. Covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.	1-25
Routine Immunizations (State Mandate)	100%, deductible and coinsurance waived (PPO and Non-PPO)	Limited to Dependent children under the age of six years. Refer to the list of covered immunizations in the text. Immunization for a Covered Person age six years and older may be payable under the Wellness Benefit.	1-26
Routine Vision Exams	PPO: 100%, deductible and coinsurance waived Non-PPO: 100%, deductible and coinsurance waived	Limited to one routine exam per Calendar Year. Includes refractions. Medically Necessary vision exams are payable under a separate benefit.	1-26

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Vision Exams (Medically Necessary)	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Routine vision exams are payable under a separate benefit.	1-26
Vision Materials (Glasses & Contact Lenses)	100%, deductible and coinsurance waived (for PPO and Non-PPO)	<p>Limited to a combined maximum of \$150 paid per Covered Person, per Calendar Year.</p> <ul style="list-style-type: none"> • Frames: One set per 24-month period. • Lenses: Once every 12 months • Contact Lenses: A one-year supply every 12 months. 	1-26
Limitations and Exclusions	Not Payable	List of exclusions that apply to all Covered Expenses. A service that is normally covered or Medically Necessary may be excluded when provided with an excluded item.	1-28
Prescription Drug Card	100% after copay	<p>Retail – 34 Day Supply: \$5 copay per generic drug/refill; \$15 copay per Preferred Brand Name drug/refill; \$30 copay per Non-Preferred Brand Name drug/refill.</p> <p>Retail – 90 Day Supply: \$10 copay per generic drug/refill; \$30 copay per Preferred Brand Name drug/refill; \$60 copay per Non-Preferred Brand Name drug/refill.</p> <p>Mail Order – 90 Day Supply: \$10 copay per generic drug/refill; \$30 copay per Preferred Brand Name drug/refill; \$60 copay per Non-Preferred Brand Name drug/refill.</p> <p>Benefits under the Prescription Drug Card Plan will apply to the Plan Lifetime Maximum shown above</p>	1-33

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered Expenses are payable, after satisfaction of the deductible, on a Usual, Customary and Reasonable basis at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

Deductible

The deductible applies to each Covered Person, each Calendar Year. Only charges which qualify as a Covered Expense may be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

Maximum Family Deductible

The total deductible applied to all Covered Persons in one family, in a Calendar Year, is subject to the maximum shown on the Schedule of Benefits. Once Your family reaches this maximum for a Calendar Year, no further deductibles will be applied during that Calendar Year.

Coinsurance

Benefits are payable at the percentage rate shown on the Schedule of Benefits, after the deductible is satisfied each Calendar Year. Benefits are payable for the rest of the Calendar Year or up to any Plan maximums, on a Usual, Customary and Reasonable basis, at the percentage rate shown on the Schedule of Benefits.

Out-of-Pocket Limit

The amount You must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of the deductible and coinsurance. When the out-of-pocket limit has been met for a Covered Person or family, the Plan will pay 100% of Covered Expenses for the rest of the Calendar Year. If You use PPO and Non-PPO providers, PPO Covered Expenses will be applied to both out-of-pocket limits. Your out-of-pocket expense for a Calendar Year will not exceed the Non-PPO limit.

This limit does not apply to Covered Expenses for psychological disorders, chemical dependence or alcoholism.

Continuity of Care

If You are undergoing a covered course of treatment from a PPO provider and that provider terminates from the PPO network during Your course of treatment, Covered Expenses that You incur from that provider for such course of treatment will continue to be paid as PPO until the earliest of the following:

1. The end of the course of treatment;
2. 90 days from the date the provider terminated as a PPO provider;
3. The end of the Calendar Year in which it was presented that the provider was, or would be, a PPO provider;
or
4. Pregnancy: If the course of treatment involves Your pregnancy and You are in Your second or third trimester at the time Your provider terminates as a PPO provider, that provider will continue to be treated as a PPO provider through post-partum care for You and Your covered newborn child

Important: This Continuity of Care provision does not apply to a provider who is no longer practicing in the service area or who has been terminated by the PPO Network for professional misconduct.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for the following services or supplies furnished by a Hospital are payable as shown on the Schedule of Benefits.

Room and Board

Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the average charge for a semi-private room in the Hospital where You are Confined.

Hospital Miscellaneous Charges

Charges made by the Hospital on its own behalf for services and supplies furnished for Your treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests; and
2. Professional services of an anesthesiologist.

QUALIFIED PRACTITIONER BENEFITS

Benefits are payable as shown on the Schedule of Benefits and include charges made by a Qualified Practitioner for the following services:

1. Home and office visits.
2. Inpatient and outpatient Hospital visits.
3. A surgical procedure or multiple or bilateral surgical procedures, wherever performed, including pre- and post operative care and subsequent care for surgeries performed in the outpatient department of a Hospital or Ambulatory Surgical Center. Diagnostic x-ray and laboratory services related to a covered surgery are also a Covered Expense under this benefit.

Subsequent surgical procedures (i.e.: suture or cast removal), which are normally considered part of the Usual, Customary and Reasonable fee for the initial surgery will only be considered for payment as a separate service when performed by a Qualified Practitioner other than the operating surgeon.

No benefits are payable for incidental procedures, such as an incidental appendectomy, unless such procedure is Medically Necessary.

4. Reconstructive surgery when due to Injury, infection or other disease of the involved part, or due to congenital disease or anomaly which resulted in a functional defect or due to a previous therapeutic process;
5. Elective sterilizations, vasectomies and tubal ligations. For Employees and Dependent spouses only;
6. Assistant surgeon services, when approved by the Plan and performed by a Qualified Practitioner who actively assists the operating surgeon in performing a covered surgery; and
7. Administration of anesthesia. The services of a registered nurse anesthetist under the supervision of an M.D. are covered when billed by the M.D..

Qualified Practitioner Benefits - continued

Oral Surgery

The following oral surgical procedures are covered, including necessary x-ray and laboratory tests:

1. Excision of partially or completely unerupted impacted teeth;
2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination,
3. Surgical procedures required to correct Accidental injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth,
4. Reduction of fractures and dislocations of the jaw;
5. External incision and drainage of cellulitis;
6. Incision of accessory sinuses, salivary glands or ducts;
7. Frenectomy (the cutting of the tissue in the midline of the tongue);
8. Functional osteotomy;
9. Osseous surgery (modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form);
10. Gingivectomy (the excision of diseased gum tissue to eliminate infection);
11. Apicoectomy (the excision of the apex of the tooth root);
12. Alveolectomy (the leveling of the structures supporting the teeth when performed for reasons other than preparation for dentures); and
13. Repair of or initial replacement of natural teeth damaged due to Injury. To be a Covered Expense under the Plan, the replacement expense must be incurred within 12 months of the Injury or within 12 months of becoming covered under this Plan, whichever is later. Damage resulting from biting or chewing will not be considered an Injury.

WELLNESS BENEFIT

Includes charges for an annual check-up or routine physical exam for You or Your covered Dependent. Covered Expenses include related charges for:

1. Routine x-ray and laboratory tests;
2. Immunizations and vaccinations (Note: Routine immunizations for a Dependent child up to age six years are payable under a separate benefit, as shown under the Other Covered Expenses section of this Plan);
3. Routine hearing tests. Limited to one routine test per Calendar Year.
4. Bone density screening;
5. Nutritional counseling. Limited to one visit per Calendar Year;

Wellness Benefit - continued

6. Routine exams for school, sports, camps, scouting and other activities that require a pre-participation exam. Limited to once per Calendar Year for each type of exam. (i.e. one for school and one for sports and one for scouting, etc.)
7. Well child care; and
8. Screening colonoscopies and flexible sigmoidoscopies.

You must not be confined in a Hospital or Qualified Treatment Facility and such expenses must not be for the diagnosis or treatment of a specific Injury or Sickness.

No benefits are payable under this provision for:

1. Medical examinations for Injury or Sickness;
2. Medical examinations related to a pregnancy;
3. Any dental examinations; or
4. Routine mammograms. (Note: These are payable under a separate benefit, as shown below.)
5. Routine pap smears. (Note: These are payable under a separate benefit, as shown below.)
6. Routine prostate tests. (Note: These are payable under a separate benefit, as shown below.) or
7. Eye examinations for the purpose of prescribing corrective lenses. (Note: These are payable under a separate benefit, as shown under the Other Covered Expenses section of this Plan.) Includes refractions.

ROUTINE MAMMOGRAMS

Routine mammograms for any covered female person. Payable as shown on the Schedule of Benefits. Limited to one routine mammogram per Calendar Year.

DIAGNOSTIC AND MEDICALLY NECESSARY MAMMOGRAMS

For any covered female person. Payable as shown on the Schedule of Benefits.

ROUTINE PAP SMEARS

Routine pap smears for any covered female person. Payable as shown on the Schedule of Benefits.

ROUTINE PROSTATE TESTS

Routine prostate tests for any covered male person. Payable as shown on the Schedule of Benefits.

OUTPATIENT HOSPITAL BENEFITS

Charges for these outpatient Hospital services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of Your Sickness or Injury;
2. Diagnostic x-rays and laboratory services;

Outpatient Hospital Benefits - continued

3. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by Your attending Qualified Practitioner;
4. Charges incurred at an urgent care facility; and
5. Emergency room charges, but **only** if incurred due to:
 - a. Emergency Accident treatment,
 - b. a surgical procedure, or
 - c. treatment of a Sickness that is a medical Emergency.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by a free standing surgical facility or Ambulatory Surgical Center, on its own behalf, for surgical procedures performed and for Hospital miscellaneous services provided in the facility.

X-RAY AND LABORATORY TESTS

Diagnostic x-ray and laboratory tests when performed by a Qualified Practitioner and not covered under the Hospital Miscellaneous Charges provision. This provision does not include dental x-rays, unless related to a covered Injury.

AMBULANCE SERVICE BENEFIT

Local professional ambulance service is payable as shown on the Schedule of Benefits. The service must be used to or from a Hospital, skilled nursing facility, or sanitarium or from Your home or the scene of an Accident or medical Emergency.

PREGNANCY BENEFIT

Pregnancy is a Covered Expense for any covered female person and payable as shown on the Schedule of Benefits. Complications of Pregnancy are payable, for any covered female person, as any other covered Sickness at the point the complication sets in.

Complications of an elective abortion are covered if the complications are life-threatening to the mother. (This is limited to treatment of the complications only. Charges for the elective abortion itself are not covered.)

Birthing classes, including Lamaze classes, are not covered. Charges incurred for home births are not covered.

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section. However, the plan or issuer may pay for a shorter stay if the attending Qualified Practitioner (e.g. Your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification.

NEWBORN BENEFITS

This benefit does **not** apply unless You enroll Your newborn Dependent within 60 days of the date of birth. See the "Eligibility" section of this booklet for more information.

A newborn child of a Covered Employee is covered during the first 60 days of life. Dependent coverage **must** be in force for coverage to continue past the first 60 days of life. If Dependent coverage is not in force at the end of the 60 days, the child's coverage will terminate immediately. However, coverage may still be effective on the child's date of birth if the following conditions are met: Coverage is applied for within 12 months of the child's date of birth and all back contributions due plus 5 1/2% interest are paid.

Covered Expenses incurred during the period of the mother's hospitalization following delivery. Hospital charges for nursery room, board and care; the Qualified Practitioner's charge for circumcision of a male newborn child; and the Qualified Practitioner's charges for routine examination of the newborn child before release from the Hospital.

Covered Expenses also include expenses incurred for the following: Injury or Sickness; necessary care and treatment for premature birth; medically diagnosed birth defects and abnormalities; and surgery to repair or restore any body part necessary to achieve normal body functioning. Covered Expenses do **not** include Expenses Incurred for plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to Injury, infection or other disease of the involved part; or
2. Congenital disease or anomaly of a covered Dependent child which resulted in a functional defect.

BIRTHING CENTER BENEFIT

Services and supplies provided in a Birthing Center for prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

HOME HEALTH CARE BENEFIT

Expense Incurred for Home Health Care, as described below, is payable under the Plan.

The maximum weekly benefit for such coverage will not exceed the Usual, Customary and Reasonable fee for weekly care in a Convalescent Nursing Home facility.

Covered Expenses are payable for up to 40 visits in any Calendar Year. If Your attending Qualified Practitioner certifies that You are terminally ill and have a life expectancy of less than six months, an additional 40 home health care visits are available per Calendar Year.

Each visit by a person providing services under a home health care plan, or evaluating the need for, or developing a plan of home health care will be considered as one home health care visit.

Up to four consecutive hours of home health aid service in a 24-hour period is considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof.

Home Health Care will **not** be reimbursed unless the Qualified Practitioner certifies that:

1. Hospitalization or Confinement in a Convalescent Nursing Home would be required if home care was not provided;

Home Health Care Benefit - continued

2. Necessary care and treatment are not available from members of Your Immediate Family or other persons residing with You, without causing undue hardship; and
3. The Home Health Care services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Care Agency or certified rehabilitation agency.

If You were hospitalized immediately prior to the commencement of Home Health Care, the Home Health Care plan must also be initially recommended by the Qualified Practitioner who was the primary provider of services during Your hospitalization.

The Home Health Care plan may consist of:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
2. Part-time or intermittent home health aide services which are necessary as part of the Home Health Care plan, provided under the supervision of a registered nurse (R.N.) or medical social worker, and which consists solely of caring for the patient;
3. Physical, respiratory, occupational or speech therapy;
4. Medical supplies, drugs and medications prescribed by a Qualified Practitioner and laboratory services by or on behalf of a Hospital, when necessary under the home care plan and to the extent such items would be covered under the Plan if You had been hospitalized;
5. Nutritional counseling provided under the supervision of a registered dietician, when such services are necessary as part of the home care plan;
6. The evaluation of the need for and the development of a plan of Home Health Care by a registered nurse (R.N.), physician assistant or medical social worker, when Home Health Care is recommended or requested by Your attending Qualified Practitioner.

CONVALESCENT NURSING HOME BENEFIT

Expense Incurred for daily room and board and general nursing services for each day of Confinement in a Convalescent Nursing Home is payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility where You are confined.

HOSPICE CARE BENEFIT

1. Room and board and related services and supplies;
2. Nursing services;
3. Bereavement counseling by a licensed clinical social worker. Bereavement counseling by a pastoral counselor;
4. Medical social services for You and Your Immediate Family under the direction of a Qualified Practitioner, including:
 - a. assessment of social, emotional and medical needs, and the home and family situation,
 - b. identification of the community resources available and assisting in obtaining those resources;

HOSPICE CARE BENEFIT - CONTINUED

5. Dietary counseling;
6. Spiritual counseling;
7. Consultation and case management services by a Qualified Practitioner;
8. Physical, occupational or speech therapy;
9. Home Health Care and related supplies;
10. Home health aide service;
11. Services of a Qualified Practitioner;
12. Medical supplies, drugs and medicines prescribed by a Qualified Practitioner; and
13. Durable medical equipment.

Hospice Care must be furnished in a Hospice Facility or by a Hospice Care Agency in Your home. Hospice Care must be instead of a covered Confinement in a Hospital or Convalescent Nursing Home. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less.

Limitations

Hospice care must be furnished in a hospice facility or by a hospice care agency in Your home. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less. For Hospice Care only, Your immediate family is Your parent, spouse and Dependent children.

Hospice care benefits do **not** include: private or special nursing services; a Confinement not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; or services by a licensed pastoral counselor to a member of his congregation.

HUMAN ORGAN AND TISSUE TRANSPLANTS

The following human organ or tissue transplants are payable when the transplant is provided from a human donor to a living human transplant recipient and the attending Qualified Practitioner certifies the medical necessity of the transplant.

1. Bone marrow transplants, when not experimental or investigational. The Covered Person must request in advance, from the Plan, a determination as to whether a bone marrow transplant is covered or is excluded as experimental or investigational;
2. Cornea transplants;
3. Arteries or veins;
4. Heart transplants;

Human Organ and Tissue Transplants - continued

5. Heart lung transplants (combined procedures);
6. Kidney transplants;
7. Liver transplants;
8. Lung transplants;
9. Pancreas transplants;
10. Kidney pancreas transplants (combined procedures);
11. Small bowel transplants; and
12. Any other tissue or organ transplant that may be covered elsewhere in this Plan.

NOTE: THE PLAN SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS YOU ARE AWARE OF THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR YOU. ACCESS TO THE TRANSPLANT NETWORK IS SUBJECT TO PLAN'S ONGOING COORDINATION.

The Plan will provide You with a list of Transplant Network facilities. It will help to coordinate Your referral and access to the facility of Your choice. Only facilities that are participating in the Transplant Network at the time of Your admission are Transplant Network facilities.

Services provided through the Transplant Network are payable subject to the Plan Lifetime Maximum.

Travel Benefits

If a Transplant Network Facility is used, the Plan will cover the following additional expenses:

- a. travel expense to and from the Designated Transplant Facility for the Covered Person and one or two parents of the Covered Person (if the Covered Person is a Dependent child) or another person to accompany the Covered Person, and
- b. lodging at or near the Transplant Facility for the Covered Person and the person(s) who accompanied the Covered Person while the Covered Person is receiving transplant-related services at a Designated Transplant Facility.

Benefits for travel expense and lodging are limited to a **maximum of \$10,000** paid per transplant.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the Designated Transplant Facility.

Further information on the Transplant Network will be provided to You as part of the pre-certification process for a transplant procedure.

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

Human Organ and Tissue Transplants – continued

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

When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient. (**Kidney Transplants**: When only the donor is covered by this Plan, no benefits are payable for the donor-related services.)

Kidney Transplants: When the transplant recipient is a Covered Person under this Plan, donor-related services are a Covered Expense under this Plan. When only the donor is covered under this Plan, no benefits are payable for the donor-related services.

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

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

The following expenses incurred by You during a plan of treatment for a psychological disorder, chemical dependence or alcoholism are payable as stated below:

1. Charges made by a Qualified Practitioner;
2. Charges made by a Hospital;
3. Charges made by a Qualified Treatment Facility.

Inpatient Benefits

Covered Expenses while confined as a registered bed patient in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits.

Outpatient Benefits

Covered Expenses for outpatient treatment received while not confined in a Hospital or Qualified Treatment Facility are payable as shown on the Schedule of Benefits. Outpatient Benefits include related expenses for diagnostic laboratory exams and psychological testing. Prescription drugs are payable under the prescription drug card.

Transitional Treatment

Covered Expenses for transitional treatment are payable as shown on the Schedule of Benefits.

Psychological Disorders, Chemical Dependence and Alcoholism Benefit – continued

Transitional treatment means treatment for psychological disorders, chemical dependence or alcoholism that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment. Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; child and adolescent day treatment programs; services for chronically psychologically ill Covered Persons provided by a community support program; services for alcohol and chemical dependent Covered Persons provided by a residential treatment program; and services for alcoholism and other chemical dependence provided in a day treatment program. Transitional treatment also includes services in intensive Outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American society of Addiction Medicine.

Limitations

Benefits do **not** include: 1) Treatment of nicotine habit or addiction; 2) Marriage counseling; or 3) Court ordered examinations or counseling.

OTHER COVERED EXPENSES

These other Covered Expenses are payable as shown on the Schedule of Benefits:

1. Chiropractic care for the treatment of an Injury or Sickness. Routine or maintenance chiropractic care is not a Covered Expense. Massage therapy is not a Covered Expense under this benefit.
2. Anesthesia and anesthesia supplies and services, including topical and infiltration anesthesia. Services must be rendered by a Qualified Practitioner who is not the operating surgeon or an assistant at the surgery.
3. Treatment by a licensed physical, speech or occupational therapist. All treatment must be to restore loss or correct impairment due to an Injury or Sickness.
4. Cardiac rehabilitation. Limited to Phase I (inpatient) and Phase II (outpatient) only. Phase II must begin within 30 days after Your discharge from the Hospital.
5. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for nursing care ordered by Your attending Qualified Practitioner. The nurse must not ordinarily reside in Your home or be a Family Member. (Private duty nursing while in a Hospital or Other Qualified Treatment Facility is not a Covered Expense.)
6. Rental/Purchase of Equipment:
 - a. Oxygen and rental of equipment for its administration; rental of equipment to treat respiratory paralysis;
 - b. Rental up to the total purchase price or when approved by the Plan purchase of a wheelchair, Hospital bed, respirator or other durable medical equipment. Limited to standard model equipment only. The equipment must be needed for therapeutic treatment, be able to withstand repeated use, primarily and customarily used to serve a medical purpose, and not generally useful to a person except for the treatment of an Injury or Sickness. Repair expenses are not covered, unless the equipment has been purchased. Repairs, due to abuse or misuse are not covered. Replacements will be covered if the equipment cannot be repaired. Routine, periodic maintenance expenses are **not** covered. Replacement batteries are not covered.

Wheelchairs are limited to ONE of the following only: a) a manual wheelchair, b) a motorized wheelchair; or a c) motorized scooter.
7. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices will only be covered when necessary due to a pathological change. Repair and maintenance expenses are not covered
8. Casts, splints, crutches, trusses braces and custom molded orthotics.
9. Orthopedic shoes. Limited to one pair per Calendar Year, unless necessary due to growth or a change in Your condition.
10. Support stockings. Limited to two per affected leg per Calendar Year.
11. Penile prosthesis (e.g. Erectaid) when impotence: a) is caused by an organic dysfunction, b) is a complication that is a direct result of a covered surgery, or c) is a result of an injury to the genitalia or spinal cord; and other accepted treatment has been unsuccessful.

Other Covered Expenses - continued

12. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip, artificial knee).
13. Blood and blood plasma, except when replaceable by a blood donor club; administration of blood; a blood processing fee charges to the Hospital by a blood bank or blood center.
14. Diabetic equipment and supplies, if they are not covered under the Prescription Drug Card. The installation and use of an insulin infusion pump, other equipment and supplies used in the treatment of diabetes, and diabetic self-management education programs are a Covered Expense. Coverage for an insulin infusion pump is limited to the purchase of one pump per year and the pump must be in use for 30 days before the initial purchase.
15. Certain supplies provided at the direction of a Qualified Practitioner, when used in the treatment of a specific disease or condition.
16. TMJ surgical and non-surgical treatment. Benefits include appliances, including, but not limited to, intraoral splint therapy devices, and therapy for any jaw joint problem. Jaw joint problems include: temporomandibular joint disorder; craniomaxillary or craniomandibular disorder; other conditions of the joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof. Elective orthodontic treatment or services are not covered. Periodontal treatment is not covered. General dental care is not covered. Cosmetic treatment is not covered.
17. Services of a Hospital or Ambulatory Surgical Center, including anesthetics, incurred for dental care provided to:
 - a. A Dependent child under the age of five years,
 - b. A Covered Person with a Chronic Disability,
 - c. A Covered Person with a medical condition which requires hospitalization or general anesthesia for such dental care.
18. Blood lead tests for covered Dependent children under the age of six years, according to recommended lead screening methods and intervals established by the rules of the Department of Health and Social Services.
19. Outpatient radiation therapy.
20. Chemotherapy.
21. Pre-admission testing.
22. Second opinions.

Other Covered Expenses - continued

23. The following immunizations are payable, as shown on the Schedule of Benefits, for any covered Dependent child from birth to the age of six years. (**Note:** This benefit is in addition to any Wellness or Well Child Care Benefit that may be part of this Plan.)
- a. Diphtheria,
 - b. Pertussis,
 - c. Tetanus,
 - d. Polio,
 - e. Measles,
 - f. Mumps,
 - g. Rubella,
 - h. Hemophilus influenza B,
 - i. Hepatitis B.,
 - j. Varicella.
24. The following services will be payable under the Plan when provided in connection with a mastectomy for which benefits are payable under the Plan and reconstructive surgery has been elected in a manner determined in consultation with the attending physician and patient:
- a. Reconstruction of the breast on which the mastectomy has been performed,
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance,
 - c. Prostheses to replace the breast on which the mastectomy has been performed, and
25. Physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).
26. Expense incurred by a Covered Person during participation in a Cancer Clinical Trial when the expense would be a Covered Expense if provided outside of the trial (e.g. lab tests for blood cell counts, CAT scans and MRIs to monitor the progress of the cancer, and anti-nausea medications).
27. Routine vision exams. Includes refractions. Limited to one routine exam per Calendar Year. (Medically Necessary vision exams are payable under a separate benefit, as shown below.)
28. Medically Necessary vision exams. (Routine vision exams are payable under a separate benefit, as shown above.)
29. Vision materials. Covers frames, lenses and contact lenses. Frames are limited to one set every 24 months. Lenses are limited to one pair every 12 months. Contact lenses are limited to a one-year supply every 12 months. Limited to a combined maximum of \$150 paid per Calendar Year.
30. Medically Necessary hearing tests.
31. Certain services or treatment of a learning disability or developmental delay. **Limited to:** a) an evaluation visit, and b) a maximum of three follow-up visits per therapy, per Calendar Year. The therapies may include physical, speech and occupational therapy. The purpose of the therapies are for home instruction and monitoring for long-term and/or maintenance conditions. **Note:** The actual treatment of these conditions is not a Covered Expense.

Other Covered Expenses - continued

32. Hospital admission kits.
33. Elective sterilization, vasectomy and tubal ligation. Covered for Employees and Dependent spouses only. (Reversals of voluntary sterilization procedures are not covered.)
34. Kidney disease benefits. Includes treatment and dialysis. (Note: kidney transplant services are payable under a separate benefit, as shown under the Human Organ and Tissue Transplant Benefit section of this Plan.)
35. Reconstructive surgery due to Injury, infection or other disease of the involved part, when the need for such surgery is not the result of or a complication of a prior cosmetic procedure. Such surgery must be incurred within 12 months after the date of the Accident or within 12 months of Your effective date under this Plan, which ever is later. (**Note:** This 12-month limit does not apply to item #24 of this section (the Women's Health and Cancer Right Act benefit.)
36. Treatment of a congenital disease or anomaly to correct a functional defect.

LIMITATIONS AND EXCLUSIONS

This Plan does **not** provide benefits for:

ALTERNATIVE TREATMENTS

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

DENTAL

1. **Dental care** or treatment, except as specifically described; or for orthognathic surgery, including osteotomy procedures of the maxilla or mandible; or
2. **Dental implantology** techniques, including prosthetic devices related to such techniques.

DRUGS

1. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a Qualified Practitioner (OTC - over the counter)**. OTC items specifically stated in this plan as a Covered Expense will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a Qualified Practitioner's office, Hospital or other facility it will be covered;
2. **Non-prescription vitamins, minerals and supplements**, even if prescribed by a Qualified Practitioner;
3. All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements. (Related supplies for this, such as feeding tubes, pumps and bags are Covered Expenses.)
4. Charges for **prescription drugs**, except when not covered by the Employer's Prescription Drug Card and not excluded under any other provision of this Plan.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Any drug or medicine which is not approved for marketing by the United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration. This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection;
2. Any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States; or
3. Any medical or surgical procedure which as of the time services are performed is conducted consistent with an experimental or investigative protocol of the United States Department of Health and Human Services or any of its subsidiary Agencies, Bureaus, Institutes or Divisions.

CESA #8 - Effective 7/1/07

Limitations and Exclusions - continued

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to Injury, infection or other disease of the involved part is a Covered Expense when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;
2. Any charges for, relating to or resulting from **sex change operations**;
3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;
4. Any treatment or services for **weight control or reduction**, whether or not prescribed by a Qualified Practitioner or associated with a Sickness. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs;
5. Any treatment of **obesity or morbid obesity**, whether or not prescribed by a Qualified Practitioner or associated with a Sickness, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy);
6. Charges for **general fitness programs, exercise programs, exercise equipment and health club memberships**; or
7. **Wigs**, toupees, hairpieces, hair implants or transplants, hair prosthesis or hair weaving.

PRE-EXISTING CONDITIONS

1. Pre-Existing conditions, as described in the Definitions section of this Plan.

PROVIDERS

1. Any service or supply:
 - a. provided while You are **not under the regular care of a Qualified Practitioner**,
 - b. **not authorized or prescribed by a Qualified Practitioner**,
 - c. authorized or prescribed by a Qualified Practitioner, but **excluded under this Plan**,
 - d. **provided for complications resulting from an elective surgery that is excluded under this Plan**,
 - e. provided **in connection with or as a result of any service or supply that is not a Covered Expense**, except as specifically stated under the Other Covered Expenses section of the Plan (e.g. the Cancer Clinical Trial benefit);
2. Services provided by a **person who ordinarily resides in Your home** or who is a Family Member;
3. **Telephone, computer or Internet consultations** between You and any provider. Completion of claim forms or forms necessary for Your return to work or school. Any appointment You did not attend; Telemedicine, except teleradiology; or
4. **Private duty nursing** while in a Hospital or other Qualified Treatment Facility.

Limitations and Exclusions – continued

REPRODUCTION

1. **Elective abortions** performed by any means including surgical and pharmaceutical methods. (Complications of an elective abortion are covered if the complications are life-threatening to the mother.)
2. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs;
3. Treatment, services or supplies for a **surrogate mother** or any pregnancy resulting from *your* service as a surrogate mother;
4. Treatment of a **sexual dysfunction**, including, but not limited to sexual counseling or therapy, implants and hormonal therapy and drugs. This exclusion does **not** apply when due to: a) organic dysfunction, b) complications of surgery, or c) an Injury and other treatment is not successful;
5. **Genetic testing or counseling**, unless Medically Necessary to treat the Sickness or Injury of a Covered Person or used in the treatment of a high risk pregnancy. (**Note:** Such treatment must be authorized by Managed Care Concepts (MCC);
6. The **reversal of voluntary sterilization** procedures;
7. Any procedure, service or supply provided to or **for the treatment of an embryo, zygote or fetus prior to birth**. This does not include services provided to the mother as part of the mother's prenatal care; or
8. **Birthing classes**, including Lamaze classes.

ROUTINE AND GENERAL HEALTH

1. **Vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders. The initial purchase of eyeglasses or contact lenses for aphakia, keratoconus and after a cataract surgery **is** a Covered Expense; (Note: routine vision exams are payable as shown under the Other Covered Expenses section of this Plan and eyeglasses and contacts are payable as shown on the Schedule of Benefits.)
2. Hearing Services: a) the purchase or fitting of hearing aids; b) Diagnostic tests, surgery, devices and related instruction or therapy for **cochlear implants**; c) augmentation communication devices and related instruction or therapy; (Note: routine hearing tests are payable as shown under the Wellness Benefit.)
3. **Prophylactic procedures** to prevent a Sickness that has not occurred yet; or **third party exams**, including, but not limited to premarital tests or examinations; third party exams; exams directed or requested by a court of law; routine physical exams for occupation, employment, travel or the purchase of insurance;
4. Any treatment or therapy that is **court-ordered, ordered as a condition of parole, probation or custody evaluation**, except for coverage that must be provided as required under s.609.65, Wis. Statutes, for a person examined, evaluated or treated for a nervous or mental disorder pursuant to an emergency detention, a commitment or a court order; or
5. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction. (Note: smoking cessation products may be payable under the Prescription Drug Card.)

Limitations and Exclusions – continued

SERVICES UNDER ANOTHER PLAN

1. Any Injury or Sickness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;
2. Any service or supply for which **no charge is made**, or for which You would not be required to pay if You did not have this coverage;
3. Any charges that **would have been paid by Your primary plan** had You complied with all of the pre-certification requirements of that plan;
4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include Medicare or Medicaid); or
5. Any service or supply provided in the care of any **service related** Injury or Sickness (past or present) **if You are in a Hospital or facility owned or operated by the United States Government** or any of its agencies.

OTHER

1. Charges **in excess of the Usual, Customary and Reasonable charge** for the service or supply;
2. Services **not Medically Necessary** for diagnosis and treatment of an Injury or Sickness;
3. **Custodial care; maintenance care;**
4. Any medical expense incurred **before Your coverage under this Plan is effective;**
5. Any medical expense incurred **after the date Your coverage under the Plan terminates**, except as specifically described. (**Note:** If You are receiving inpatient care in a Hospital on the date that Your coverage terminates, benefits will continue to be payable for Covered Expenses incurred for that Confinement. If You are Totally Disabled, benefits will continue as outlined under the “Extension of Benefits” provision in Section Three of this Plan.)
6. Charges incurred **outside the United States** if You traveled to such location to obtain the service, drug or supply;
7. Any medical expense due to commission or attempt to **commit a civil or criminal battery or felony;**
8. Any medical expense incurred as a result of **engaging in an illegal occupation;**
9. Any loss caused or contributed to by:
 - a. **war or any act of war**, whether declared or not,
 - b. any act of international armed conflict, or any conflict involving armed forces of any international authority; or
 - c. riots, insurrection or acts of terrorism;
10. **Educational testing or training or recreational therapy;**

Limitations and Exclusions - continued

11. **Vocational or industrial rehabilitation**, including work hardening programs;
12. Services or treatment for **behavioral problems, learning disabilities, developmental delays**, or other medical conditions that do not constitute a distinct medical diagnosis; except as specifically stated; (Services for pervasive developmental disorders, including autism, are for a diagnostic evaluation only. Other services specifically for pervasive developmental disorders are not covered, except as stated;)
13. **Habilitative services**. (Services that are educational in scope and purpose and are provided to develop, improve or accelerate functions that have never been present or are not present to the normal degree of function for Your like age and sex);
14. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;
15. The treatment of psychological disorders, chemical dependence or alcoholism except as stated;
16. Inpatient Hospital admissions which are primarily for physical, speech or occupational therapy or for x-ray or radiation therapy;
17. Charges for **modifications to Your vehicle, home or property**, such as, but not limited to, escalators, elevators, saunas, steambaths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars or ramps;
18. Charges for **environmental items**, such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices;
19. **Marriage counseling**;
20. Services, supplies, equipment and facilities that are Covered Expenses under more than one provision of this Plan. Such Covered Expenses will be considered for payment under only one provision;
21. **Cranial banding**;
22. **Personal comfort or convenience items**; or
23. **Travel and transportation for a consultation or to receive treatment**, except as stated for ambulance services.

PRESCRIPTION DRUG CARD

You will receive an identification (ID) card. It will show Your name, ID number, group number and effective date. Eligibility is on-line.

A directory of participating pharmacies is available on the Drug Card's web site. The directory contains the name, address and phone number of the pharmacies that are part of the Drug Card. If You are unable to access the Drug Card's website, please contact Your Employer.

Covered Drugs

Your Drug Card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." Your pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on Your ID card. A complete list of covered and excluded drugs is available on the Drug Card's web site. If You are unable to access the Drug Card's web site, You may contact the Drug Card service at the number shown on Your ID card.

How To Use The Prescription Drug Card

Present the ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If You are without Your ID Card or at a non-participating pharmacy, You may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from the Employer.

Mail Order Drug Service

If You are using an on going prescription drug, You may purchase that drug on a mail order basis. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an on going medical condition and are taken on a regular basis.

The copay for mail order prescriptions is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card's web site or from the Employer. All prescriptions will be mailed directly to Your home.

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SECTION 2 DEFINITIONS

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DEFINITIONS

Accident

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

Actively at Work

An Employee is Actively at Work if he or she is employed by the Employer on a regular basis and meets the minimum requirements set by the Employer for eligibility under the Plan, except that an Employee is not considered Actively at Work if he or she has been laid off or is absent from work for reasons other than those which entitle the Employee to leave under family and medical leave laws or a Health Factor, and such layoff or absence from work is for such a period of time that the employee is no longer eligible for the benefits of this Plan pursuant to the rules or policies established by the Employer or the terms of any applicable collective bargaining agreement.

Ambulatory Surgical Center

Any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery and does not provide services or accommodations for patients to stay overnight.

Amendment

A document, duly authorized by the Plan Administrator, that changes any provision of the Plan.

Birthing Center

A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the Birthing Center; 2. Is directed by a Qualified Practitioner specializing in obstetrics and gynecology; 3. Has a Qualified Practitioner or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Business Associate

A Business Associate is a person who provides, other than in the capacity of a Plan Employee, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Plan where the provision of the service involves the disclosure of individually identifiable health information from the Plan or from another Business Associate to the person.

Calendar Year

A 12 month period of time that starts on January 1 and ends on December 31.

Definitions - continued

Chronic Disability

A disability which meets all of the following requirements: 1) It is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) It is likely to continue indefinitely; 3) It results in substantial functional limitations in one or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, capacity for independent living and economic self sufficiency.

Claims Administrator

The person or entity employed by the Plan Administrator to provide administrative services in connection with the operation of the Plan and any other functions including the processing of claims. If no Claims Administrator is employed by the Plan Administrator, Claims Administrator will mean the Plan Administrator.

Complications of Pregnancy

A Sickness or Injury superimposed upon an otherwise normal pregnancy. The Sickness or Injury must have the potential to affect the course or outcome of the pregnancy, or the health of the mother or fetus. Examples of Complications of Pregnancy are preeclampsia, toxemia, gestational diabetes, hyperemesis, gravidarium, ectopic pregnancy, miscarriage and gynecological surgery performed in the six week postpartum period (other than elective sterilization) if the surgery is in connection with or results from the pregnancy. Complications do not include false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness and similar conditions associated with a difficult pregnancy.

Confinement

Being a resident patient in a Hospital for at least 15 consecutive hours per day or being a resident bed patient in a Convalescent Nursing Home or other Qualified Treatment Facility 24 hours a day. Successive Confinements are considered one Confinement if they are:

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

Convalescent Nursing Home

An institution or part of an institution, which is lawfully run in the jurisdiction where it is located and maintains and provides:

1. Permanent and full-time bed care facilities for resident patients;
2. A Qualified Practitioner's services available at all times;
3. A registered nurse (R.N.) or Qualified Practitioner in charge and on full-time duty and one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and
5. Continuous skilled nursing care for sick or injured persons during their convalescence from Sickness or Injury.

Definition of Convalescent Nursing Home - continued

Convalescent Nursing Home does not include an institution which is principally a rest home or a home for care of the aged, or a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

Convalescent Nursing Home Confinement

Convalescent Nursing Home Confinement is only a Confinement in a Convalescent Nursing Home which:

1. Begins while You or Your covered Dependent are covered under this Plan;
2. Begins within 24 hours after discharge from a Hospital Confinement;
3. Is necessary for care or treatment of the same Injury or Sickness which caused the prior Hospital Confinement; and
4. Occurs while You or Your covered Dependent are under the regular care of the Qualified Practitioner who certified the required Convalescent Nursing Home Confinement.

Covered Dependent

An Employee's eligible Dependent who is properly enrolled in the Plan.

Covered Employee

An Employee who is eligible and properly enrolled in the Plan.

Covered Expense

Expense Incurred by You or Your Covered Dependent for services or supplies provided by a Qualified Practitioner or Qualified Treatment Facility due to an Injury or Sickness if the Expense Incurred is covered by the Plan.

Covered Person

A Covered Employee or Covered Dependent

Custodial Care

Care to assist in the activities of daily living and care that is not likely to improve Your medical condition.

Definitions – continued

Dependent

1. A covered Employee's lawful spouse, as defined in the State where *you* reside, provided that:
 - a. the spouse is not legally separated from the Employee, and
 - b. the Employee is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;
2. A Covered Employee's never married child whose age is less than the limiting age. A Child includes a natural blood related child; a step-child; a legally adopted child; or a child placed with the Employee for adoption.

The limiting age for each Dependent child is the earliest of:

- a. The date the Dependent child marries, or
 - b. 19 years, or
 - c. 25 years, if such child is in regular full-time attendance, as determined by the school, at a State recognized high school or an accredited college, university or other institution of higher education as defined by Federal law (20 USC 1088);
3. A Covered Employee's grandchild, as long as the Employee's Covered Dependent child, who is the parent of the grandchild, is not yet 18 years old.

A Covered Dependent child who attains a limiting age while covered under this Plan will remain eligible for benefits if the Plan Administrator determines that all of the following conditions exist at the same time:

1. The child is mentally retarded or physically handicapped;
2. The child is incapable of self-sustaining employment because of mental retardation or physical handicap;
3. The child is chiefly dependent on the Covered Employee for support and maintenance; and
4. The child never married.

You must provide satisfactory proof that the above conditions exist within 31 days after the date the limiting age is reached. The Plan Administrator may request such proof annually after two years from the date the limiting age is reached. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

No person may be covered as both an Employee and a Dependent at the same time. If both the Employee and spouse are eligible for coverage under this Plan, only one may enroll for Dependent coverage.

A child will **not** be eligible for coverage under this Plan if he or she:

1. Is married; or
2. Is covered as a Dependent of another Employee; or
3. Is eligible for his or her own medical insurance under this Plan or under another group policy.

Definitions - continued

Effective Date

The effective date stated on the front of this Plan.

Emergency

Any Injury or Sickness which requires immediate treatment and which if not immediately treated would jeopardize or impair the health of the Covered Person. An Emergency may or may not be life threatening.

Employer

Cooperative Educational Service Agency 8 (CESA 8)

Employee

You, when You are regularly employed by the Employer. For purposes of this Plan, Employee does not include temporary Employees; members of the Board of Directors; an owner, partner or officer, unless he or she is working for the Employer on a regular basis; or an independent contractor or consultant who is paid on other than a regular wage or salary by the Employer..

Enrollment Date

The first day of Your eligibility period or if earlier, Your effective date of coverage under this Plan. If You are a Late Applicant Your Enrollment Date is Your effective date of coverage under this Plan.

Expense Incurred

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

Family

A Covered Employee and the Covered Employee's Covered Dependents.

Family Member

Your lawful spouse. Your child and step-child. Your grandchild. Your parent. Your grandparent. Your step-parents. Your step-grandparents. Your brother or sister. Your step-brother or step-sister. Your half-brother or half-sister. Any person related in the same way to Your covered Dependent.

Health Factor

The health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including whether an individual is a victim of domestic violence or engages in activities, such as motorcycling, horseback riding, snowmobiling or similar activities, or disability of and Employee or Dependent of any Employee.

Definitions - continued

Home Health Care

Medical care or treatment provided by a Home Health Care Agency to You in Your home due to Your Sickness or Injury and pursuant to a Home Health Care Plan, or services of a Qualified Practitioner or Home Health Care Agency in evaluating the need for or in developing a Home Health Care Plan.

Home Health Care Agency

A public or private agency or organization which:

1. Specializes in providing medical care and treatment in the home;
2. Is primarily engaged in providing skilled nursing services and other therapeutic services;
3. Is duly licensed by all appropriate authorities;
4. Has a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) , and establishes policies to govern the services provided;
5. Has a Qualified Practitioner or registered nurse (R.N.) providing full-time supervision of the services provide;
6. Maintains a complete medical record on each patient;
7. Has a full-time administrator; and
8. Is certified by Medicare.

Home Health Care Plan

A written plan developed by a Qualified Practitioner or Home Health Care Agency describing the frequency and type of Home Health Care to be provided. The Home Health Care Plan must be reviewed by a Qualified Practitioner at least once every two months, unless the Qualified Practitioner determines that a longer interval between reviews is sufficient. The Home Health Care Plan must include one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
2. Part-time or intermittent home health aide services provided under the supervision of a registered nurse (R.N.) or medical social worker, and which consists solely of caring for the patient;
3. Physical, respiratory, occupational or speech-language pathology therapy;
4. Medical supplies, drugs and medications prescribed by a Qualified Practitioner and laboratory services by or on behalf of a Hospital to the extent such items would be covered under the Plan if You had been confined to a Hospital; or
5. Nutritional counseling provided under the supervision of a registered dietician.

Hospice Care

Palliative and supportive care to terminally ill patients and their families.

Definitions – continued

Hospice Care Agency

An agency which:

1. has the primary purpose of providing Hospice Care to hospice patients;
2. is licensed and operated according to the laws of the state in which it is located;
3. has obtained any required certificate of need;
4. provides 24-hour-a-day, seven-day-a-week service, supervised by a Qualified Practitioner;
5. has a full-time coordinator;
6. keeps written records of services provided to each patient;
7. has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients;
8. has a licensed social service coordinator;
9. establishes policies for the provision of Hospice Care; assesses the patient's medical and social needs and develops a program to meet those needs;
10. provides an ongoing quality assurance program;
11. permits area medical personnel to use its services for their patients; and
12. uses volunteers trained in care and services for non-medical needs.

Hospice Care Program

A written plan of Hospice Care which is established and reviewed by a Qualified Practitioner and the Hospice Care Agency, and describes palliative and supportive care to hospice patients and their Immediate Families.

Hospice Facility

A licensed facility or part of a facility which:

1. principally provides Hospice Care;
2. has 24 hour a day nursing services, provided under the direction of a registered nurse (R.N.);
3. has a full-time administrator;
4. keeps medical records of each patient;
5. has an ongoing quality assurance program; and
6. has a Qualified Practitioner on call at all times.

Definitions – continued

Hospital

An institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a Qualified Practitioner and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where it is located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Hospital does **not** include an institution which is principally a rest home, nursing home, convalescent home or a home for the aged. Hospital does **not** include a place principally engaged in the care or treatment of alcoholics, drug addicts or persons with psychological disorders.

Immediate Family

Your spouse, children, parents, grandparents, brothers and sisters and their spouses.

For Hospice Care only, Your Immediate Family is Your parent, spouse and Dependent Children.

Injury

Physical damage to Your body caused by an external force and due, directly and independently of all other causes, to an Accident.

Inpatient Treatment

Treatment while confined as a registered bed patient in a Hospital or Qualified Treatment Facility.

Late Applicant

An Employee or an Employee's eligible Dependent who enrolls or is enrolled for coverage more than 31 days (60 days for newborns and adopted children) after his or her initial eligibility date.

Lifetime

The entire time You are covered under this Plan, whether or not Your coverage is continuous.

Medically Necessary

A service or supply provided by a Hospital or Qualified Practitioner that is required to identify or treat Your Sickness or Injury and which is, as determined by the Plan Administrator:

1. Consistent with the symptom(s) or diagnosis and treatment of Your Sickness or Injury;

CESA #8 - Effective 7/1/07

Definition of Medically Necessary - continued

2. Appropriate under the standards of acceptable medical practice to treat that Sickness or Injury;
3. Not solely for convenience; and
4. The most appropriate service or supply which can be safely provided to You and accomplishes the desired end result in the most economical manner.

Medicare

Title XVIII, Parts A and B, of the Social Security Act as amended.

Outpatient Treatment

Treatment received while not confined in a Hospital or Qualified Treatment Facility, including diagnostic laboratory examinations and psychological testing.

PPO

Preferred Provider Organization. If a provider has contracted with the PPO Network, they are a PPO Provider. PPO providers furnish services at a discounted rate to the Plan. If a provider has not contracted with the PPO Network, they are a Non-PPO provider.

Plan

The plan of medical expense benefits described in this document and including any schedules, attachments and Amendments to this document. Prior, current and successive plans will be considered one plan and not separate and distinct plans.

Plan Administrator or Trust

WCA Group Health Trust.

Plan Sponsor

The Plan Sponsor of the Plan is WCA Group Health Trust

Pre-Existing Condition

A Sickness or Injury for which medical advice, diagnosis, care or treatment was recommended to or received by You during the six month period immediately prior to Your Enrollment Date under this Plan.

Pre-existing conditions are covered after the end of a period of:

- a. 12 months from Your Enrollment Date, if You are not a Late Applicant, or
- b. 18 months from Your Enrollment Date, if You are a Late Applicant.

Pre-Existing Condition Exceptions

The Pre-Existing Condition Limitation will not apply:

1. To any Covered Expenses resulting from pregnancy,

Definition of Pre-Existing Condition – continued

2. To a newborn Dependent child. Such child must be enrolled for coverage within 60 days of the date of birth. A child that is provided coverage under the Mother's plan of benefits will be considered to be enrolled as of the date of birth,
3. To a *dependent* child that is adopted or placed for adoption prior to their 18th birthday. Such child must be enrolled for coverage within 60 days of the adoption or placement and
4. To any condition that has not been diagnosed by a Qualified Practitioner, but has been indicated by genetic testing.

Pre-Existing Condition Credit

Credit will be given under the pre-existing condition limitation, for all benefits, to the extent of *your* continuous coverage, without a lapse of more than 63 days. Coverage under any of the following plans is creditable: a. a group health plan; b. group, individual or other form of health insurance; c. Medicare (Part A, B or C); d. Medicaid; e. the Active Military Health Program or TRICARE; f. a medical program of the Indian Health Service or of a tribal organization; g. a State sponsored health benefits risk sharing pool; h. the Federal Employees Health Plan; i. a Peace Corp. Health Program; j. a public health plan that provides health coverage by insurance or other means including any plan established by the U.S. government, a State, a foreign country, or any political subdivision thereof; k. a State Children's Health Insurance Program (CHIPs).

When *you* have coverage under a plan, *you* have the right to request written proof of that coverage at any time. When *your* coverage under a plan ends, *you* will be given written proof of coverage under that plan. It is *your* responsibility to provide this *plan* with this proof of coverage. If *your* prior plan did not provide *you* with proof of *your* coverage, this *plan* will assist *you* in providing proof of coverage by other means. Upon receiving proof of *your* prior coverage, *you* will be notified if there is any remaining pre-existing condition limit that may be applied.

Protected Health Information

Protected Health Information means individually identifiable health information that is: transmitted or maintained in any form or medium; is created or received by a health care provider, the Plan an employee or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual.

Qualified Practitioner

A practitioner licensed to treat Sickness or Injury, who is providing services within the scope of that license. A practitioner who resides in Your home or is a Family Member is not covered.

Qualified Treatment Facility

A duly licensed facility, institution or clinic, operating within the scope of its license, which provides treatment for a cause for which benefits are payable under the Plan, including a facility established for treatment of psychological disorders, chemical dependence and alcoholism. These facilities do not include Hospitals.

Definitions – continued

Sickness

1. A disease or disturbance in function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of Your body.
2. Muscle tiredness or soreness resulting from overexertion in a physical activity; or
3. Pregnancy.

Total Disability or Totally Disabled

Your inability due to Sickness or Injury to perform the substantial full-time duties of any job with the Employer. You also cannot work for wage or profit for anyone, including Yourself.

For Dependents, it means the inability due to Sickness or Injury to carry on all of the normal activities of a healthy person of the same age and sex.

Transitional Treatment

Treatment for nervous or mental disorders, alcoholism or other drug abuse that is provided in a less restrictive manner than Inpatient Treatment, but in a more intensive manner than Outpatient Treatment.

Usual, Customary and Reasonable (UCR)

For Non-PPO Providers, the lesser of:

1. The fee most often charged by the provider; or
2. The maximum allowable fee as determined by the Plan Administrator by comparing similar services or procedures to a national data base adjusted to the locality where the services or procedures were performed.

In the case of a PPO Provider, it means the negotiated PPO discount rate for the service or procedure.

You and Your

You as the Covered Employee and any of Your Covered Dependents, unless otherwise provided.

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SECTION 3 ELIGIBILITY

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Employees who were covered under any plan that this Plan replaces will be covered on the effective date of this Plan. Coverage will include Dependents of such an Employee. You must have met the eligibility requirements of this Plan.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the Plan if You are an Employee who meets the eligibility requirements of the Employer.

If You are hired between the first day of the month and the 15th day of the month, You are eligible to be covered on the first day of the month in which You were hired. This is Your eligibility date.

If You are hired between the 16th day of the month and the end of the month, You are eligible to be covered on the first day of the following month. This is Your eligibility date.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms furnished and accepted by the Plan Administrator. Each Employee's effective date of coverage is determined as follows:

1. If Your completed enrollment forms are received by the Plan Administrator within 31 days of Your eligibility date, Your coverage is effective on Your eligibility date.
2. If Your completed enrollment forms are received by the Plan Administrator **more than** 31 days after Your eligibility date, this is considered **late enrollment**. Your coverage will be effective on the first of the month coinciding with or following the date Your completed enrollment forms are received by the Plan Administrator.

Employee coverage will begin at 12:01 AM, Standard Time, on Your effective date. You must actually begin performing work with the Employer before coverage will be effective under the Plan.

DEPENDENT ELIGIBILITY

Each Dependent is eligible for coverage on the later of:

1. The date the Employee is eligible for coverage, if the Employee has Dependents on that date;
2. The date of the Covered Employee's marriage for any Dependents acquired on that date;
3. The date of birth of the Covered Person's natural born child;
4. The date a child is placed with the Covered Employee for adoption; or
5. The date a child is adopted by the Covered Employee.

Dependents of an Employee may be covered only if the Employee is also covered.

If both the Employee and a Dependent are eligible for Employee coverage under this Plan, each Covered Expense is payable only once and each Covered Person is covered only once.

DEPENDENT EFFECTIVE DATE

Each Dependent's effective date of coverage is determined as follows:

1. If a Dependent's completed enrollment forms are received by the Plan Administrator within 31 days of the Dependent's eligibility date, that Dependent is covered on his or her eligibility date.
2. An eligible newborn of a Covered Person is covered for 60 continuous days from the moment of birth. If the newborn's enrollment forms are received by the Plan Administrator within 60 days of the date of birth, then the newborn will be a Covered Dependent effective the moment of birth.
3. If the newborn's enrollment forms are received by the Plan Administrator more than 60 days and within one year after the date of birth and the Covered Employee makes all past due premium payments with interest at the rate of 5 ½% per year, then the newborn will be a Covered Dependent effective the moment of birth.
4. If You marry after Your coverage is effective, You should apply for Family Coverage within 31 days of Your marriage. If You do, Your Family Coverage becomes effective on the date of the marriage.
5. If a Dependent's completed enrollment forms are received by the Plan Administrator more than 31 days after the Dependent's eligibility date, this is considered **late enrollment**. Coverage for that Dependent will be effective on the first of the month coinciding with or following the date the Dependent's completed enrollment form is received by the Plan Administrator.

Dependent coverage will begin at 12:01 AM, Standard Time, on the Dependent's effective date of coverage under the Plan.

A Dependent who becomes an eligible Employee, is no longer eligible as a Dependent.

SPECIAL ENROLLMENT RIGHTS

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Applicant provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

Loss of Other Coverage

If You declined coverage under this Plan in favor of other group coverage or COBRA continuation and coverage under the other group plan or COBRA:

1. Ends due to Your exhaustion of the maximum COBRA period;
2. Ends due to Your loss of eligibility, for any reason;
3. Ends benefits due to Your reaching the Lifetime maximum for all benefits; or
4. Ends employer contributions towards the cost of the other coverage;

A special enrollment event has occurred. At that time, an Employee or Dependent may be enroll in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependent may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;

Special Enrollment Rights - continued

2. When a Dependent has a loss of coverage, that Dependent, the Employee and other eligible Dependents that are not enrolled may enroll. The Employee and the Dependents do not have to have had a loss of coverage at that time to enroll.

You must enroll in this Plan within 31 days of the date of a loss of other coverage to be a timely entrant to the Plan. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this Plan will not be effective until such proof is provided. Coverage under this Plan will be effective on the day coverage under the other group plan ends.

If You apply more than 31 days after the date the other coverage ends, you will be Late Applicants under this Plan.

Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage and any other Dependents that were not previously covered under the Plan may also be enrolled at this time.

You must enroll in this Plan within 31 days of the date of marriage to be a timely entrant to the Plan. Coverage under the Plan will be effective on the day of Your marriage.

If You apply more than 31 days after the date of Your marriage, it will be considered late enrollment under this Plan.

Birth, Adoption or Placement for Adoption

If You experience the birth of a Dependent child, or the adoption or placement for adoption of a Dependent child, a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse and the newborn or adopted child may also be enrolled at this time. Any other Dependents that were not covered under the Plan may also be enrolled at this time and they will not be considered Late Applicants.

You must enroll in this Plan within 31 days of the date of birth, adoption or placement to be a timely entrant to the Plan. Coverage under the Plan will be effective on the date of such an event.

If You apply more than 31 days after the date of such an event, it will be considered late enrollment under this Plan.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all *employees* and *dependents*. Any change in coverage will be effective on the date of change for all *employees* and *dependents*.

REINSTATEMENT OF COVERAGE

If You return to work within six months of a termination due to layoff or approved leave of absence, Your coverage will be effective on the day You return to work. The pre-existing condition exclusion will be waived to the extent it was already satisfied.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. For any benefit, the date removal of the benefit from the Plan by Amendment is effective;
3. The last day of the month in which the last premium collection is made either by You or on Your behalf;
4. The date You enter the full-time military, naval or air service of any country;
5. The last day of the month in which You cease to be eligible according to the eligibility requirements of the Employer;
6. For all Employees, the last day of the month in which Your termination of employment with the Employer occurs or, if earlier, the last day of the month in which You are no longer Actively at Work as defined in this Plan; (**NOTE:** Contracted Employees who are non-renewing at the end of a school year will have coverage through August 31 of that same year.)
7. For Employees, the day of the month in which Your retirement occurs;
8. For a Dependent, the date the Employee's coverage terminates;
9. For a Dependent, the last day of the month in which that Dependent no longer meets this Plan's definition of a Dependent;
10. For an Employee's spouse, the date of entry of a judgement of divorce or annulment of the marriage;
11. The date You request termination of coverage to be effective for Yourself and/or Your Dependents; or
12. The date You die.

IMPORTANT NOTICE FOR EMPLOYEES WHO ARE ACTIVELY AT WORK AND SPOUSES AGE 65 OR OLDER

The Plan cannot terminate Your coverage due to age or Medicare status. An active Employee that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or
2. End coverage under this Plan, in which case Medicare would be the only coverage available to You.

An active Employee's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.

Contact Your Employer for further information.

EXTENSION OF MEDICAL BENEFITS – INDIVIDUAL TERMINATION

If You are receiving inpatient care on the day that Your coverage would otherwise end under this Plan, benefits for the condition causing You to be inpatient may be continued until the earliest of the following:

1. The date You are no longer inpatient;
2. The end of a period of 90 consecutive days after Your termination date;
3. The period of time equal to the length of time that You were covered under this Plan prior to Your termination date; or
4. The date You reach any benefit maximums under this Plan.

Benefits are payable only for Covered Expenses incurred due to the Sickness or Injury that caused the inpatient stay.

All other provisions and limitations as stated in the Plan will apply to this extension of benefits.

COBRA continuation will be offered at the time this extension period begins. If COBRA is rejected, COBRA will not be offered at the end of this extension period. If COBRA is elected, it will run concurrently with this extension period and COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA.

The Plan must remain in effect for this provision to apply.

EXTENSION OF MEDICAL BENEFITS – GROUP TERMINATION

If You are Totally Disabled on the date this Plan terminates, benefits for the condition causing You to be disabled will be continued. They will continue until the earliest of the following:

1. The date You are no longer totally disabled;
2. The end of a period of 12 consecutive months after Your termination date;
3. The date You reach any benefit maximum for that benefit; or
4. The date coverage is provided under another group medical plan, other than temporary coverage for the disability.

All other provisions and limitations as stated in the Plan will apply to this extension of benefits.

COBRA continuation will be offered at the time this extension period begins. If COBRA is rejected, COBRA will not be offered at the end of this extension period. If COBRA is elected, it will run concurrently with this extension period and COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA.

The Plan must remain in effect for this provision to apply.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to Employers with 50 or more Employees. It requires that coverage under this Plan be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the Employee as it would have been had FMLA leave not been taken.

If this Plan is established while You are on FMLA, coverage for You will be effective on the same date it would have been had You not taken FMLA leave. If provisions under the Plan change while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken FMLA leave.

EMPLOYEE ELIGIBILITY

An Employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The Employee has been employed with the Employer for a total of at least 12 months;
2. The Employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
3. The Employee is employed at a worksite that employs at least 50 Employees.

FAMILY AND MEDICAL LEAVES

Coverage under this Plan can be continued during a period of FMLA leave. Coverage under FMLA leave is limited to 12 weeks during the 12 month period that follows:

1. The birth of the Employee's child;
2. The placement of a child with the Employee for adoption. The placement of a child with the Employee for foster care;
3. The Employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition; or
4. The Employee taking leave due to a serious health condition which makes him unable to perform the functions of his position.

Maximum Leave Period

During any one 12 month period, the maximum amount of FMLA leave that may be taken is 12 weeks. If the Employee and the Employee's spouse are both employed by the Employer, FMLA leave may be limited to a combined total of 12 weeks, for both spouses, when FMLA leave is due to:

1. The birth or placement of a son or daughter;
2. The care of a parent with a serious health condition.

FMLA - continued

Termination Before the Maximum Leave Period

If the Employee decides not to return to work, coverage under the Plan may end at that time.

If the Plan contribution is not paid within 30 days of its due date, coverage under the Plan may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an Employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions

The Employer has the right to recover the portion of Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave. If the Employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work. Reinstatement will apply whether coverage under the Plan was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived. The pre-existing condition limit will be credited as if You had been continually covered under the Plan .

DEFINITIONS

For this provision only, the following terms are defined as stated below:

Serious Health Condition is any Sickness, Injury, impairment or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;
2. Continuing treatment by a Qualified Practitioner, including any period of incapacity:
 - a. for more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or a Qualified Practitioner is consulted at least once and a continuing treatment program is provided;
 - b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
 - c. due to a chronic condition (i.e. a condition which requires periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
 - d. which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective;
 - e. to receive multiple treatments from a Qualified Practitioner for restorative surgery due to Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

FMLA - continued

Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is Your lawful husband or wife.

Son or Daughter is Your natural blood related child, adopted child, step-child, foster child, a child placed in Your legal custody or a child for which You are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or
2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is Your natural blood related parent or someone who has acted as *your* parent in place of Your natural blood related parent.

NOTE: To the extent that State or local law requires an Employer to provide greater leave rights than those stated above, this Plan will provide that greater right. For complete information regarding Your rights under the FMLA, contact Your Employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that the Employer provide a cumulative total of five years, and in certain instances more than five years, of military leave during an Employee's employment with the Employer.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that the Employer continue to provide coverage under this Plan, during a military leave that is covered by the Act, for You and Your Dependents. Coverage provided must be identical to coverage provided under the Employer's Plan to similarly situated, active Employees and Dependents. This means that if the coverage for similarly situated, active Employees and Dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the Employee contribution required for active Employees;
2. For military leaves of 31 days or more, up to 102% of the full contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages. Short and long term disability and life benefits are not subject to this provision.

For the Employer subject to COBRA, continued coverage provided under this Act will reduce any continuation provided under COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Employer following completion of Your military leave. Employees must return to employment within:
 - a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
 - b. 14 days of completing military service, for leaves of 31 to 180 days,
 - c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date Your leave began.

USERRA – continued

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day of completing Your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing Your military service, for leaves of 31 to 180 days;
3. 90 days of completing Your military service, for leaves of more than 180 days.

If, due to a Sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived and the Pre-Existing Condition Limitation will be credited as if You has been continually covered under the Plan from You original effective date.

This waiver of limitations does not provide coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veterans Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

CONTINUATION AND CONVERSION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to Employers that have 20 or more employees. The law requires these Employers to offer covered individuals continuation coverage (COBRA) under the Plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The Employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active Employees under the Plan. This means that when coverage is changed for similar active Employees it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work; or
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part.

Spouse Rights to COBRA

The spouse of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;
3. The death of the Employee;
4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The Employee becoming entitled to Medicare.

Dependent Child Rights to COBRA

The Dependent child of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;
2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;
3. The death of the Employee;
4. The end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

COBRA – continued

5. The employee becoming entitled to Medicare; or
6. The child ceasing to be considered a Dependent child as defined in this Plan.

Electing COBRA

Each person covered by this Plan has an independent right to elect COBRA for himself or herself. A covered Employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the Employee's Dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the Employee during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, *you* have a right to elect COBRA. You also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the Employer files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, You must inform the Plan Administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. *You* must also inform the Plan Administrator within 60 days of a child no longer meeting the Plan's definition of Dependent. The Employer must notify the Plan Administrator of: the Employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The Employer must also notify the Plan Administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the Plan Administrator will notify You that You have the right to elect COBRA. If the employer and plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law You must elect COBRA within 60 days from the later of: the date You would lose coverage or cost would increase due to the qualifying event; or the date notice of Your right to COBRA and the election form are sent.

The Plan Administrator must provide You with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If You elect COBRA within the 60 day period, COBRA will be effective on the date that You would lose coverage. If You do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the Plan will terminate.

COBRA - continued

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The Plan may add a 2% administration charge to that cost. The Plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the Plan Administrator.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the Employer maintain COBRA for up to:

1. 18 months, if due to the Employee's termination of employment. Termination must be for reasons other than gross misconduct on the Employee's part;
2. 18 months, if due to the Employee's reduction in work hours;
3. 36 months, if due to the death of the Employee;
4. 36 months, if due to the end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. 36 months, if due to the Employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the Employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;
6. 36 months, if due to Your ceasing to be a Dependent child as defined in the Plan; or
7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the Employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered Dependent may elect COBRA for an additional 36 months from that date.

If You or a Dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if You or a Dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the Plan Administrator within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, You will not be eligible for the extended period. If it is determined that You are no longer disabled, You must notify the Plan Administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the Employee's death; the Employee's divorce; a child no longer meeting the definition of Dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

COBRA - continued

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the Plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The Employer no longer provides a group benefit plan to any of its Employees;
2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to You. You will have 30 days from the date of notice to make the additional payment;
3. You obtain another group plan after the date You elect COBRA. This will not apply if that group plan has a pre-existing condition exclusion or limit that applies to You. If such limit or exclusion has been met by a credit from Your previous coverage, this provision will apply. If Your new plan does have a pre-existing condition exclusion or limit that applies to You, then COBRA will end on the earlier of: the date that exclusion or limit no longer applies to You; or the end of the maximum coverage period;
4. You become entitled to Medicare after the date You elect COBRA;
5. There has been a final determination that You are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Additional Election Period due to The Trade Act of 2002

If You did not elect COBRA during the election period described above, another 60 day period may be presented for You to elect COBRA. If Your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and You are determined to be TAA eligible during the six month period following Your loss of coverage, You will have an additional period in which to elect COBRA. This election period will begin the first of the month in which You become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following Your loss of coverage due to a TAA event.

If You elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which You became TAA eligible. COBRA will not be provided for the period of time between Your loss of coverage and the first of the month in which You became TAA eligible. However, that time will not be counted as a lapse in coverage for purposes of determining if the Plan's pre-existing condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date You lost coverage under the Plan, not the date COBRA is effective. If You do not elect COBRA within this period, COBRA will not be available again.

COBRA - continued

If You elect COBRA, it is Your duty to pay all of the monthly payments directly to the Plan Administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 65% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If You have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact/2002act_index.asp.

Procedures for Providing Notice to the Plan

In order to maintain Your rights under COBRA, *you* are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if You provide written notice to the Plan Administrator that includes:

1. The Employee's name and social security number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The Plan Administrator will answer any questions You may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to Your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect Your rights under COBRA, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status; address; or other insurance coverage. When providing any notice to the plan, a copy should be maintained for Your own records. When COBRA ends, You will have the right to Conversion coverage, if offered by this Plan.

INDIVIDUAL CONVERSION PLAN

If an individual conversion plan is available from the Trust, the Plan Administrator will, during the 180 day period before the applicable end of continuation coverage, offer a Covered Person who is covered until the end of the maximum period of continuation coverage the option of enrollment under a conversion health plan.

If an individual conversion health plan is not available from the Trust, a Covered Person may continue group coverage until:

1. The individual on continuation coverage establishes residence outside this state.
2. The individual on continuation coverage fails to make a timely payment of a required premium amount.

COBRA – continued

3. For an individual on continuation coverage who is eligible for continued coverage as the former spouse of a Covered Person and who would otherwise terminate coverage because of divorce or annulment, the Covered Person through whom the former spouse originally obtained coverage is not longer eligible for coverage by the Plan.
4. The individual on continuation coverage becomes eligible for similar coverage under another Plan.

SECTION 4 GENERAL PLAN INFORMATION

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COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans which also cover You. This is to prevent the problem of overinsurance and a resulting increase in the cost of coverage.

EFFECT ON BENEFITS

Benefits will be reduced under certain circumstances when You are covered both under this Plan, as described, and any other plan, as defined below, which provides similar benefits. Total reimbursement from all plans will not exceed 100% of the total Covered Expenses under this Plan.

This coordination of benefits provision applies whether or not You file a claim under any other plan You may be covered under.

DEFINITION

For this Coordination of Benefits provision only, a plan is any coverage which covers medical, dental or vision expenses and provides benefits or services by: :

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

This includes group type contracts not available to the general public obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket or in something else.

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

HOW COORDINATION OF BENEFITS WORKS

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Covered Expenses. These plans are called secondary plans.

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

Coordination of Benefits - continued

ORDER OF BENEFIT DETERMINATION

A plan will be considered the primary plan and pay benefits first if.

1. The plan has no coordination of benefits provision; or
2. The plan covers the person as an Employee.
3. When a Dependent child is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering a parent for the longest period of time will pay benefits first. If a plan other than this Plan does not include a provision similar to this one, then this provision will be ignored in order to coordinate benefits with the other plan.
4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
 - a. the plan of a parent who has primary physical placement will be primary,
 - b. the plan of a step-parent that has primary physical placement will pay benefits next,
 - c. the plan of a parent who does not have primary physical placement will pay benefits next, and
 - d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

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

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

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

Subject to the order of benefit determination stated above, if both grandparents in a household are providing coverage for a grandchild, the plan of the grandparent whose birthday (month and day) occurs first in the Calendar Year will pay before the plan of the other grandparent. If both grandparents in a household have the same birthday, the plan covering a grandparent for the longest period of time will pay benefits first.

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

Coordination of Benefits - continued

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this Plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan are subject to the allowable limiting charges, as set by Medicare, and will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

RIGHT TO NECESSARY INFORMATION

The Claims Administrator has the right to decide which facts it needs to apply and coordinate these provisions with other plans. It may get needed facts from or give them to any other organization or person without consent of the insured, but only as needed to apply these provisions. Medical records remain confidential as provided by state law. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this Plan, You agree to all of the following conditions. The payment of any claims by the Plan is an advancement of Plan assets. The Plan has first priority to receive repayment of those Plan assets out of any amount You recover. The Plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before You receive payment from that party. The Plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The Plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not You are made whole.

The Plan will not pay attorney fees without the express written consent of the Plan Administrator. The Plan will not pay any costs associated with any claim or lawsuit without the express written consent of the Plan Administrator.

If You are deceased, the rights and provisions of this section will apply equally to Your estate. If You are legally incapacitated the rights and provisions of this section will apply equally to Your legal guardian.

In consideration of the coverage provided by this Plan, when You file a claim You agree to all of the following conditions. You will sign any documents that the Plan considers necessary to enforce its recovery rights. You will do whatever is necessary to enable the Plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the Plan any rights You have for expenses the Plan paid on Your behalf. You will hold any settlement funds in trust, either in a separate bank account in Your name or in Your attorney's trust account, until all Plan assets are fully repaid or the Plan agrees to disbursement of the funds in writing, if You receive payment from any liable or responsible party and the Plan alleges that some or all of those funds are due and owed to the Plan. You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the Plan. It also includes any medical, dental or loss of time expense that may be payable by the Plan in the future.
2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; You or Your Covered Dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the Plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of Your benefits under this Plan.

Right of Subrogation

If, after payments have been made under this Plan, You have a right to recover damages from a responsible or liable party, the Plan shall be subrogated to that right to recover. The Plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the Plan.

Recovery Rights - continued

Right of Reimbursement

If benefits are paid under this Plan, and You recover from a responsible or liable party by settlement, judgment or otherwise, the Plan has a right to recover from You. Recovery will be in an amount equal to the amount of Plan assets paid on Your behalf. The Plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of Plan assets that are paid or payable for any health care expenses under the Plan.

Excess Coverage Provision

Benefits are not payable for an Injury or Sickness if there is any responsible or liable party providing coverage for health care expenses You incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the Plan may make payments on Your behalf for Covered Expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the Plan and will be considered an advancement of Plan assets to You.

This Plan does not provide benefits or may reduce benefits for any present or future Covered Expenses that You have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the Plan.

WORKER'S COMPENSATION

This Plan is not issued in lieu of, nor does it affect any requirement for coverage by any worker's compensation or occupational disease act or law.

If You are eligible to receive worker's compensation benefits for any Injury or Sickness sustained in the course of any occupation or employment, no benefits are payable under the Plan for that Injury or Sickness.

The Plan Administrator reserves the right to exercise the Plan's recovery rights even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that Injury or Sickness was sustained in the course of or resulted from Your employment;
3. The amount of Workers' Compensation due to medical, dental or health care expense is not agreed upon or defined by You or the Workers' Compensation carrier; or
4. The medical, dental or health care benefits are specifically excluded from the Workers Compensation settlement or compromise.

You must notify the Plan Administrator of any worker's compensation claim You make. You agree to reimburse the Plan as described above.

GENERAL PROVISIONS

ALTERNATE RECIPIENTS

If a court order requires a Covered Person to provide health care coverage for a Dependent child, coverage must be provided to the child. Coverage may not be subject to Plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of Dependents are also waived for that child. If a Covered Person does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an Employee under the Plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the Plan. They must be provided with a copy of the Plan's Summary Plan Description (SPD). Any payments made by the Plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

A court order will not entitle the child to any benefits or coverage not already offered by the Plan.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan's benefits may be amended by the Employer at any time. The Plan may be terminated by the Employer at any time. Any changes to the Plan will be communicated immediately by the Employer to the persons covered under the Plan.

If the Plan is terminated, the rights of the Covered Persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. Plan assets will be allocated to the exclusive benefit of the Covered Persons. Any taxes and expenses of the Plan may be paid from the Plan assets.

ASSIGNMENT

Any assignment will only be applied to the extent that the provider of services will refund any erroneous payments. The Plan Administrator does not guarantee the legal validity or effect of any assignment.

CLAIM REVIEW PROCEDURE

You may seek review of denial of a claim by submitting a written request for review to the Claims Administrator, who will forward it to the Plan Administrator's claims review committee. The written request for review must be received by the Claims Administrator within 60 days after the mailing of written notice of grant or denial of the claim or the amount of benefits to be paid. After receiving a timely request for review, the claims review committee will schedule a hearing. At the hearing, the Covered Person and any other party affected by the decision or action may present evidence and argument. The claims review committee will issue a written decision within 60 days after the end of the hearing, affirming, modifying or setting aside the previous decision or action. The written decision of the claims review committee will be based on the record of the hearing and shall be final, except as otherwise required by law

General Provisions - continued

CLERICAL ERROR

A clerical error by the Employer, the Plan Administrator, or the Claims Administrator will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

CONFORMITY WITH APPLICABLE LAWS

If any provision of this Plan is contrary to any applicable law, that provision is amended to conform with such law and the rest of the Plan remains in effect.

CONTRIBUTIONS TO THE PLAN

The Plan is funded by contributions from the Employer Covered Employees. The Employer reserves the right to adjust or modify such contributions.

COOPERATION

You must cooperate with the Plan Administrator, Claims Administrator, and or any person designated by the Plan Administrator in connection with this Plan.

FAILURE TO ENFORCE PLAN PROVISIONS

No failure to enforce any provision of the Plan will affect the right, thereafter, to enforce such provision or affect the right to enforce any other provisions of the Plan.

FREE CHOICE OF PROVIDER

The Covered Person has a free choice of any legally licensed provider. The Plan will not interfere with the provider/patient relationship.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

This Plan is not financed or administered by an insurance company and benefits are not guaranteed by a contract of insurance.

If You have any questions about Your rights under the Health Insurance Portability and Accountability Act of 1996, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 2000 Constitution Avenue, N.W., Washington D.C. 20210.

LEGAL ACTIONS

You cannot bring an action to compel payment under the Plan until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the Plan has denied full payment of Your claim, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

General Provisions - continued

PAYMENT OF CLAIMS

Any payment made in good faith will fully discharge the Plan to the extent of such payment. If benefit payments have been made under any other plan which should have been made under this Plan, the Plan Administrator may reimburse such plan. Any payments made in good faith will fully discharge the Plan's obligations to You to the extent of such payment.

Benefits will be paid directly to the provider of services, unless You direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of You or Your Covered Dependent, upon death, will be paid at the Plan Administrator's option to:

1. Your estate;
2. Your spouse;
3. Your Dependent children;
4. Your parents; or
5. Your brothers and sisters.

PHYSICAL EXAMINATION

The Plan Administrator, at its own expense, has the right to have You examined as often as it deems reasonably necessary while a claim is pending.

PRIVACY OF PROTECTED HEALTH INFORMATION

1. Plan Sponsor's Certification of Compliance

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Plan Sponsor

- a. The Plan and any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of Wisconsin law and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Such disclosure will include disclosure for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in the Plan's Notice of Privacy Practices. Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.

Privacy of Protected Health Information – continued

- b. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.
- c. Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

3. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information

- a. The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.
- b. The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' Protected Health Information.
- c. The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
- e. The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524 and any applicable Wisconsin law.
- f. The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526 and any applicable Wisconsin law.
- g. The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528 and any applicable Wisconsin law.
- h. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E ("Privacy of Individually Identifiable Health Information").

Privacy of Protected Health Information – continued

- i. The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium, received from the Plan or any Business Associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information that cannot feasibly be return or destroyed to those purposes that make the return or destruction of the information feasible.
- j. The Plan Sponsor will ensure that the required adequate separation, described in detail in paragraph 4, below, is established and maintained.

4. Adequate Separation Between the Plan Sponsor and the Plan

- a. The following persons under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a Business Associate servicing the Plan:

Employees of Wisconsin Counties Association who hold the positions of Director of Insurance Services, Director of Administration and Finance, Insurance Services Administrator, Operations Manager, Executive Administrative Assistant, Administrative Assistant.

All employees of all entities with whom the Plan has entered into Business Associate Agreements to the extent those employees perform tasks for or on behalf of the Plan and/or the Plan Sponsor.

This list includes every employee or class or employees or other persons under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The employees or other persons above shall also be given access to Plan Participants' Protected Health Information for the purpose of rendering final claim appeal determinations.

- b. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.
- c. The employees, classes of employees or other persons identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

Privacy of Protected Health Information – continued

5. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

- a. The Plan may disclose Summary Health Information (SHI) to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information (SHI) for the purpose of:
 1. Obtaining premium bids for the health coverage offered under the Plan; or
 2. Modifying, amending or terminating the Plan.

Summary Health Information (SHI) includes aggregated claims history, claims expenses or types of claims experienced by enrollees in the Plan. Although this information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the SHI as belonging to a particular participant.

- b. The Plan may disclose enrollment and disenrollment information to the Plan Sponsor.

PROOF OF LOSS

You must give written proof of loss to the Claims Administrator as soon as reasonably possible and, in any event, within 16 months after the date of loss.

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

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind and any attempt to accomplish these will be void. If the Plan Administrator finds that such an attempt has been made, the Plan Administrator, at its sole discretion, may terminate the interest of the Covered Person in the payments and apply the amount of the payment to or for the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan to the extent of the payment.

REPRESENTATIONS

All representations by a Covered Person are material and relied upon in providing coverage under the Plan.

SECURITY

The WCA Group Health Trust, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Trust certifies to the Plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

Security Provision – continued

2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Employer under this provision;
3. Report to the Plan any security incident that the Trust becomes aware of; and
4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

TERMINATION OF THE PLAN

If the Plan is terminated, the rights of the Covered Persons to benefits are limited to claims incurred and payable by the Plan before the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of Covered Persons, except that any taxes and administration expenses may be paid from the Plan assets.

TIME OF PAYMENT OF CLAIMS

Benefits due under the Plan will be paid as soon as reasonably possible upon receipt of written proof of loss.