

SAWYER COUNTY

UMR

2700 MIDWEST DRIVE, ONALASKA, WI 54650

**Group Number:
WCA0058**

Medical Benefit Plan

Customer Service:

CONNECTIONS TEAM

Toll Free 1-800-236-2515 Extension # 102

Preferred Provider Network:

United Health Care

P.O. Box 266, Onalaska, WI 54650

1-800-651-8231

UTILIZATION REVIEW

Hospital Admission Notification

You must call:

1. For proposed inpatient hospital admissions.
2. For emergency admission, call within 48 hours following an emergency admission.

**Telephone Number:
1-800-542-6643**

Sawyer County Human Resources Department
10610 Main, Suite 23
Hayward, WI 54843

phone: 715 638-3218 fax: 715 634-8262
email: hrdirector@sawyercountygov.org



To: All Employees

From: Sawyer County

Date: 9/29/13

Re: Affordable Care Act (ACA) Health Insurance Marketplace Notice

As you may be aware, the Affordable Care Act (ACA) was enacted into law on March 30, 2010. Various provisions of the law have gone into effect since that time with additional provisions going into effect in 2014. One of the key components of the law taking effect in 2014 is the ability to buy health insurance on the new Health Insurance Marketplace (formerly referred to as the Exchange).

As required by the ACA, attached is a notice about the new government Health Insurance Marketplace that is effective January 1, 2014 with enrollments beginning October 1, 2013. We want to highlight some key points about the notice:

- The intent of the notice is to inform individuals that there is a new online way to locate, compare and purchase health insurance.
- For individuals that are not offered "affordable" health coverage, or if health coverage does not meet the "minimum value" standard set by the law, they may be eligible for a subsidy that lowers their monthly premium.

For those of you eligible for Sawyer County health plan, we believe that the coverage is affordable, meaning that your contribution for single coverage is less than 9.5 percent of your household income. In addition, the Sawyer County plan also meets the "minimum value" coverage that is defined under ACA, therefore the federal government will not provide subsidy to you and your family.

A few things you should know in the event you choose to purchase a health plan through the marketplace instead of accepting health coverage offered by Sawyer County:

- You will lose the county's contribution (if you are eligible) to the district health plan
- The cost of coverage through the marketplace is often excluded from income for federal and state income tax purposes. That means your payments for coverage through the marketplace are made on an after-tax basis.

The ACA includes an Individual Mandate that states individuals are required to have health coverage or pay a penalty. In 2014, the penalty will be the greater of \$95 or one percent of household income. The tax rises to the greater of \$695 or 2.5 percent of household income by 2016.

We encourage you to review this information and to be a smart health care consumer. If you are enrolled in the Sawyer County health insurance plan you are not required to do anything differently than you have in the past. Health insurance is a key component of Sawyer County's benefits package and we encourage you to stay informed on our plans as well as what is happening with the Affordable Care Act.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

Michelle Jepson at 715-638-3218

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name SAWYER COUNTY		4. Employer Identification Number (EIN) 39-6005742	
5. Employer address 10610 Main Street		6. Employer phone number 715-638-3218	
7. City Hayward		State WI	9. ZIP code 54843
10. Who can we contact about employee health coverage at this job? MICHELLE JEPSON			
11. Phone number (if different from above)		12. Email address hrdirector@sawyercountygov.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.

Some employees. Eligible employees are: Employed by Sawyer County as a regular Full-time or regular Part-time basis. (See Your Summary Plan Description for a complete description)

- With respect to dependents:

We do offer coverage. Eligible dependents are: Employee's lawful spouse. Married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in employee's legal guardianship by court order; or employee's has a legal obligation to provide full or partial support; and whose age is not beyond 26. (See your Summary Plan Description for a complete description)

We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process.



WCA GROUP HEALTH TRUST

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER THROUGH THE HUMAN RESOURCES DEPARTMENT.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a group health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the plan at that time.

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations

Federal law allows a group health plan to use and disclose PHI, for the purposes of treatment, payment and health care operations, without your consent or authorization. Examples of the uses and disclosures that we, as a group health plan, may make under each section are listed below:

- Treatment.** Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a group health plan we do not provide treatment.
- Payment.** Payment refers to the activities of a group health plan in collecting premiums and paying claims under the plan for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine coordination of benefits or settle subrogation claims; providing PHI to the plan's Utilization Review Company for precertification or case management services; providing PHI in the billing, collection and payment of premiums and fees to plan vendors such as PPO Networks, Utilization Review Companies, Prescription Drug Card Companies and reinsurance carriers; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.
- Health Care Operations.** Health Care Operations refers to the basic business functions necessary to operate a group health plan. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate the plans performance or the performance of a particular network or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the plan; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the plan; disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to the plan; and use of PHI in general data analysis used in the long term management and planning for the plan and company.

Other Uses and Disclosures Allowed Without Authorization

Federal law also allows a group health plan to use and disclose PHI, without your consent or authorization, in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.
- To the U.S. Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to perform services for the group health plan.
- To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's Office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses.
- In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example to notify authorities of a criminal act.
- As required to comply with Workers' Compensation or other similar programs established by law.
- To the Plan Sponsor, as necessary to carry out administrative functions of the plan such as evaluating renewal quotes for reinsurance of the plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the plan is case managing.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures

You have the right to request that the plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

The plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the plan maintains the PHI. A designated record set contains claim information, premium and billing records and any other records the plan has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as the plan maintains the PHI. The plan may deny your request for amendment if it determines that the PHI was not created by the plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the plan after April 14, 2004 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the plan or the U.S. Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed in this Notice. The plan will not retaliate against you for filing a complaint.

PRIVACY CONTACT

You may contact the Privacy Officer for the plan through your employer's Human Resources Department.

EFFECTIVE DATE OF NOTICE

This notice published and becomes effective on April 14, 2004.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on April 14, 2004.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how we are most likely to use and/or disclose your protected health information.

Payment and Health Care Operations

We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. 164.501 for a complete list.

Payment

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: 1) to provide you with information about one of our disease management programs; 2) to respond to a customer service inquiry from you; or 3) in connection with fraud and abuse detection and compliance programs.

Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, Benefit Plan Administrators, Co, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

Plan Sponsor

We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Others Involved in Your Health Care

With your approval, we may disclose to family members, close personal friends, or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with worker’s compensation programs.

Authorization

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Personal Health Information.

You have the right to request restrictions on how we use or disclose your personal health information for payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Carol Larson, Human Resources Manager.

A form to request a restriction can be obtained from the Human Resources Office. We are not required to agree to your request for a restriction. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Receiving Confidential Communication of Your Personal Health Information.

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternate manner or at an alternate location. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Carol Larson, Human Resources Manager. Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial information to the plan participant (e.g., an EOB). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan sponsor.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that you contact us at the number listed in the summary page of this Notice ***as soon as*** you determine that you need to restrict disclosures of your protected health information.

Access to Your Personal Health Information.

You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated record set, with a couple of exceptions. To request access to your information, you must send a written request to: Carol Larson, Human Resources Manager. A form to request access to your personal health information can be obtained from the Human Resources Office. A fee will be charged for copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in the Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Amendment of Your Personal Health Information.

You have the right to request an amendment to your personal health information to correct inaccuracies. To request an amendment, you must send a written request to: Carol Larson, Human Resources Manager. A form to request an amendment to your personal health information can be obtained from Human Resources Office.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Accounting of Disclosures of Your Personal Health Information.

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operation, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

To request an accounting, you must send a written request to: Carol Larson, Human Resources Manager. A form to request an accounting of your personal health information can be obtained from Human Resources Office.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2004. The first list you request within a 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Right to Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed in this Notice. A copy of a complaint form is available from this office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Human Resources Manager in the lower level of the Courthouse, at 634-3218.

Please take a minute to make sure...

- You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.
- You have either filled out the credit card section on the front of this order form or included a check or money order for the required copayment.
- You have written your Member ID number on any check or money order.
- The Medco Health address on the front shows through the window of the return envelope.
- You have filled out the Health, Allergy and Medication Questionnaire. This information will help Medco Health better serve your prescription drug needs.

Expedited shipping available

You should allow 7-11 days for normal delivery of your medications. For an additional fee, your order will be shipped by an expedited service offered to your area. This option must be chosen when you make the order, and cannot be applied after an order is already processed.

Additional Instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all mail service pharmacy orders, whether or not they are covered by your plan. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit no additional orders will be processed until the balance is paid.

You can call 1-800-948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance or pay by phone using a credit card.

Ohio Law allows a less expensive, generically equivalent drug to be substituted for certain brand name drugs unless you or your physician direct otherwise.

Get more information from our website

Visit us at www.medcohealth.com



10000000000000

Medco Health
P.O. Box 2026
Pine Brook, NJ 07058

3623457
PXWCA00580001



SAMPLE Q. JOHN
123 ANY STREET
ANYTOWN, US 12345-6789

Welcome to Your New Prescription Drug Benefit Program

Dear SAMPLE Q. JOHN:

We are pleased to introduce Medco Health as your prescription drug benefit program administrator. Medco Health is the new name for Merck-Medco and PAID Prescriptions.

Medco Health is the acknowledged leader and most experienced full-service prescription drug benefit manager in the nation. Its strengths include:

- A network of more than 56,000 local and chain pharmacies nationwide
- Convenient mail service pharmacies for easy ordering of refills
- A wide assortment of personalized Internet services (medcohealth.comTM)
- Sophisticated drug-use checks and balances
- 24 hours a day, 7 days a week clinical hot line for patients
- Well-trained member service representatives

Enclosed in this packet you will find:

- A brochure explaining your enhanced prescription drug benefit in full
- A health questionnaire to help us better serve your health and prescription needs
- A form for ordering medications from the Mail Service Pharmacy
- A return envelope for the questionnaire and order form

Your prescription drug ID card is being sent to you in a separate mailing.

If you have any questions, please contact Member Services at 1 800 818-6634 or register for personalized information at www.medcohealth.com.

Sincerely yours,

Medco Health

Medco Health is rated No. 1 in overall satisfaction with pharmacy plan, 1998 and 1999/2000. Rated No. 1 in overall satisfaction with mail service pharmacy, 1999 and 2000. Based on independent surveys conducted by Caredata.com Consumer Research Group, White Plains, NY, 1998-2000. Information on file.

Medco Health is a subsidiary of Merck & Co., Inc.



862345701

Health, Allergy & Medication Questionnaire



Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for pharmacy benefits with Medco Health Home Delivery Pharmacy Service™.
- If you need additional forms you may call your Member Services toll free number or you may print a form on-line at www.medcohealth.com.
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact

- -

Group Number Member Number
(Located on your pharmacy benefit card and/or in your benefits information) Daytime Telephone Number

Member/Subscriber First Name M.I. Last Name

Street Address/Apt. No. City State Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their name, date of birth and gender. For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If your medication is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: Please use blue or black ink.

	Member	Spouse	Dependent	Dependent	Dependent
First Name: Add last name if different than member					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	<input type="radio"/> M <input type="radio"/> F				
Penicillin/Cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	<input type="radio"/>				
Tetracycline Antibiotics	<input type="radio"/>				
Erythromycin, Biaxin®, Zithromax®	<input type="radio"/>				
Codeine (e.g. Tylenol #3)	<input type="radio"/>				
Non-steroidal anti-inflammatory (NSAID) drugs (e.g. Ibuprofen)	<input type="radio"/>				
Aspirin (e.g. Salicylates)	<input type="radio"/>				
Sulfa drugs	<input type="radio"/>				
Iodine	<input type="radio"/>				
Print other drug allergies not listed above in the space provided, i.e. - <i>Morphine</i>					



Section 3: Medical Conditions

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said **that particular family member** has the condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	<input type="checkbox"/>				
High blood pressure (hypertension)	<input type="checkbox"/>				
Heart attack or angina	<input type="checkbox"/>				
High cholesterol (hypercholesterolemia)	<input type="checkbox"/>				
Stroke	<input type="checkbox"/>				
Chronic bronchitis or emphysema (COPD)	<input type="checkbox"/>				
Asthma	<input type="checkbox"/>				
Allergies, runny nose, hay fever (allergic rhinitis)	<input type="checkbox"/>				
High blood sugar (diabetes)	<input type="checkbox"/>				
Thyroid disease	<input type="checkbox"/>				
Peptic, stomach, or duodenal ulcer	<input type="checkbox"/>				
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="checkbox"/>				
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="checkbox"/>				
High pressure in the eyes (glaucoma)	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>				
Poor circulation in the legs (peripheral vascular disease)	<input type="checkbox"/>				
Trouble with blood not clotting properly	<input type="checkbox"/>				
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="checkbox"/>				
Arthritis	<input type="checkbox"/>				
Osteoporosis	<input type="checkbox"/>				
Depression	<input type="checkbox"/>				
Migraine headaches	<input type="checkbox"/>				
Print other medical conditions not listed above in the space provided, i.e.- <i>Glaucoma</i>					

For more information about Medco Health, please visit us online
at www.medcohealth.com.

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank you very much.



962345703



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State Income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

Michelle Jepson at 715-638-3218

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name SAWYER COUNTY		4. Employer Identification Number (EIN) 39-6005742	
5. Employer address 10610 Main Street		6. Employer phone number 715-638-3218	
7. City: Hayward		8. State: WI	9. ZIP code: 54843
10. Who can we contact about employee health coverage at this job? MICHELLE JEPSON			
11. Phone number (if different from above)		12. Email address: hrdirector@sawyercountygov.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.

Some employees. Eligible employees are: Employed by Sawyer County as a regular Full-time or regular Part-time basis. (See Your Summary Plan Description for a complete description)

- With respect to dependents:

We do offer coverage. Eligible dependents are: Employee's lawful spouse. Married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in employee's legal guardianship by court order; or employee's has a legal obligation to provide full or partial support; and whose age is not beyond 26. (See your Summary Plan Description for a complete description)

We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Preventive Health Services

Expanded Health Plan Coverage Guideline

(Effective 1/01/13)



WCA GROUP HEALTH TRUST

Type of Preventive Service	
Female Examinations	Gynecological exams, including pap smears & mammograms; Counseling for genetic testing for BRCA breast cancer gene & high risk breast cancer; screening for osteoporosis.
Male Examinations	Screening for prostate cancer and for abdominal aortic aneurysm.
Children Examinations	Well Child Care; Screening for hearing, thyroid disease, phenylketonuria, sickle cell anemia, metabolic screening panel for inherited enzyme deficiency diseases, major depressive disorders, developmental delay/autism, and lead and tuberculosis.
Female Examinations (Prenatal)	Routine prenatal obstetrical office visits/low risk, uncomplicated pregnancies; All lab services explicitly required in HHS rules; Tobacco cessation counseling specific to pregnant women; and Immunizations, especially directed to pregnant women.
Screening for Diabetes	Diabetes screening for women and men covered for pregnancy and hypertension.
Human Papillomavirus (HPV) DNA Testing	All Women Age 30 and Older
Counseling for Sexually Transmitted Infections	All Women and Men
Counseling and screening for human immune-deficiency (HIV) virus	All Women and Men
Counseling For and Payment of FDA-Approved Contraceptive Methods, Including Sterilizations	All Methods, all Women and Men \$0 Copay: Oral contraceptives, Vaginal Contraceptives, Emergency Contraceptives, & Injections, generic prescriptions when available.
Breastfeeding Support, Supplies, and Counseling	Part of pre/post-natal counseling, coverage for rental of breast-feeding equipment required by prescription (does not include over the counter products).
Screening and Counseling for Domestic Violence	All Women and Men
Dependent Coverage (Effective 1/01/12)	Dependent Coverage ends at the end of the month your dependent turns age 26. Dependent Coverage will continue after age 26 if your dependent is disabled or is returning from active duty from the military and continuing their education.
Questions?	If you have any questions on your coverage or claims, please call UMR at 1-800-236-8672.



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WCA GROUP HEALTH TRUST

To: Sawyer County – Employees/Retirees

As of 9/23/12, the Affordable Care Act is requiring that we provide you with the attached Summary of Benefits and Coverage, or SBC. The SBC is an easy-to-understand summary about your health plan's benefits and coverage with the WCA Group Health Trust. This new regulation is designed to help you better understand and evaluate your health insurance choices.

The new form includes:

- A short, plain language Summary of Benefits and Coverage, or SBC. The summary does include a new standardized plan comparison tool called "coverage examples". The coverage examples will illustrate sample medical situations and describe how much coverage the plan would provide in an event such as having a baby or managing Type 2 diabetes. These are sample illustrations and should not be used to determine your coverage and costs.
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment".

Please note that if you are a retiree on Medicare and have Medicare Part D, the deductible, out of pocket maximum, and prescription drug portions will not apply to you.

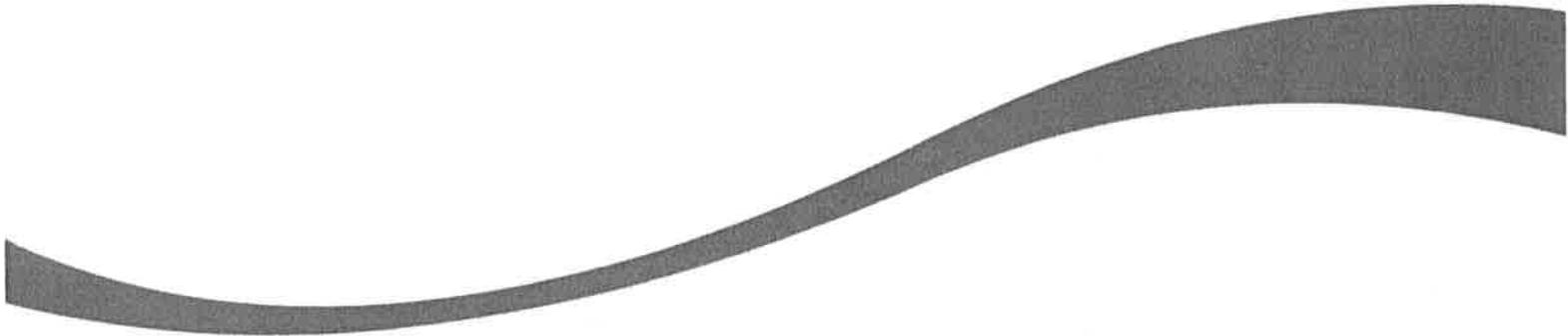
Also enclosed are the new Preventative Health Services and Expanded Health Care Coverage Guidelines available to you through the Affordable Care Act on 1/01/13.

After your review the enclosures, you have any questions or need any additional information regarding your coverage through the WCA Group Health Trust, please call UMR at 1-800-236-8672 or visit them at www.umar.com.



WCA Group Health Trust
Sawyer County
Medical Benefit Plan

Group Number: WCA0058
Revised: April 1, 2010



Online Services from UMR

Accessing Online Services

1. Visit: www.umar.com
2. Select "Members"
3. For members with health or dental coverage: Enter the member ID located on your ID card in the Online Services Access box.
4. Click "Go to my online services." Our Web site will redirect you to your online services home page.
5. When you link to umar.com for the first time, you will need to create a username and password to register for online services. Click the **Need a Username? Register here.** link and follow the prompts to complete your registration.

Claim, Eligibility and Benefit Inquiry

You can view your claims, including copies of explanations of benefits (EOBs), eligibility or benefits information, including a copy of your summary plan description (SPD), any time of the day or night.

Other Insurance and Accident Details

If you have claims pending for updates to other insurance or accident details information, you can make those updates online.



ID Card Ordering

Order duplicate or replacement ID cards quickly and easily.

Member Health Information

UMR provides a wealth of information and services to help you live a healthier life, including tools to help you make the best decisions about health conditions and prescription drugs.

In addition, we provide links to excellent health information sites, articles, and a whole lot more.

(continued on back)



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Provider Network Links

For your convenience, we've set up a link to your provider network. When you click on the link, the network provider's home page is displayed. You can click the link on the home page to search for in-network physicians or medical facilities.

Forms

Our most widely used forms are available online for easy access.

Questions?

If you have any questions or problems with your online services, please contact our technical support team at **1-866-922-8266** between 8 a.m. and 5 p.m. Central time, or reference our online tutorial guides.

If you have questions about a claim or the benefits available to you and your dependents, call us at the number on your ID card.

*UMR provides a
wealth of information
and services to help
you live a healthier life.*



UMRSM

A UnitedHealthcare Company

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SECTION 1 MEDICAL BENEFITS

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

NOTICE REQUIREMENTS

The Utilization Management company (UM) shown on Your ID card will handle the notice requirements of Your Plan. You should call the UM as soon as possible to receive proper care coordination. However, You must call within the time frames shown below. The UM toll-free number is shown on the back of Your ID card.

NOTICE REQUIRED	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
<p><u>Inpatient Admissions</u>, including, but not limited to: a Hospital; Convalescent Nursing Home; Inpatient Rehabilitation Center; Home Health Care; Inpatient Hospice or other inpatient Qualified Treatment Facility</p>	<p>PPO: No Penalty</p> <p>Non-PPO: \$250 per occurrence. This penalty applies to <u>inpatient services only</u>.</p> <p>The penalty is taken after applying the deductible and coinsurance provisions of the <i>plan</i>. The penalty is not applied to the out-of-pocket limit.</p>	<p><i>PPO: <u>Your PPO provider</u></i> is required to notify UM.</p> <p><i>Non-PPO: <u>You</u></i> must call UM at least 48 hours in advance of any non-Emergency <i>inpatient admission</i>. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require You to notify UM. If Your admission is on an Emergency basis, UM must be notified within 48 hours, or as soon as possible, after Your admission.</p> <p>If You do not notify UM, benefits will be payable after the non-compliance penalty.</p>	1-14

Notification does not guarantee benefit payment. Benefits are subject to all Plan provisions.

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.**

NOTE: UMR, Inc. is the Plan's Claims Administrator. UMR, Inc. provides clerical and claim processing services to the Plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the Plan, nor is UMR, Inc. a fiduciary to this Plan.

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 (\$200 Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee + 1 Family	 \$0 \$0 \$0 \$0 \$0 \$0	 \$200 \$400 \$600 \$200 \$400 \$600	The amount You must pay each year before the Plan will begin paying any benefits. PPO and Non-PPO Employee +1 and Family maximums are on an aggregate dollar basis.	1-13
Individual Coinsurance per Calendar Year PPO Non-PPO	 100% 80%	 0% 20%	Applies to the first \$2,500 (Individual) or \$5,000 (Employee + 1 and Family) After the deductible, the coinsurance amounts shown above apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-13

MEDICAL BENEFITS (\$200 Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Out-of-Pocket Limit per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee +1 Family		 \$200 \$400 \$600 \$700 \$1,400 \$1,600	Represents the total paid by You for the deductible and coinsurance. After which the Plan pays 100% of Covered Expenses subject to any maximums. PPO and Non-PPO Employee + 1 and Family maximums are on an aggregate dollar basis. Your out-of-pocket expense for a Calendar Year will never exceed the Non-PPO out-of-pocket limit.	 1-13
<p>All Covered Expenses under the Plan are payable at the Plan's Usual, Customary and Reasonable limits. The deductible and coinsurance limits shown above apply to all Covered Expenses unless stated otherwise below.</p> <p>PPO Benefit Provision PPO Benefits will be payable for Non-PPO provider services only if 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.</p>				

Schedule of Benefits - continued

MEDICAL BENEFITS (\$1,200 Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee + 1 Family	\$0 \$0 \$0 \$0 \$0 \$0	\$1,200 \$2,400 \$3,600 \$1,200 \$2,400 \$3,600	The amount You must pay each year before the Plan will begin paying any benefits. PPO and Non-PPO Employee +1 and Family maximums are on an aggregate dollar basis.	1-13
Individual Coinsurance per Calendar Year PPO Non-PPO	100% 80%	0% 20%	Applies to the first \$2,500 (Individual) or \$5,000 (Employee + 1 and Family) After the deductible, the coinsurance amounts shown above apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-13
Out-of-Pocket Limit per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee +1 Family		\$1,200 \$2,400 \$3,600 \$1,700 \$3,400 \$4,600	Represents the total paid by You for the deductible and coinsurance. After which the Plan pays 100% of Covered Expenses subject to any maximums. PPO and Non-PPO Employee + 1 and Family maximums are on an aggregate dollar basis. Your out-of-pocket expense for a Calendar Year will never exceed the Non-PPO out-of-pocket limit.	1-13

All Covered Expenses under the Plan are payable at the Plan's Usual, Customary 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 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.

Schedule of Benefits – continued

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-15
Qualified Practitioner Office Services Benefit	\$20 copay per visit/100% (for PPO and Non-PPO)	This copay does not apply to the out-of-pocket limits. The deductible and coinsurance are waived for this benefit. This copay applies to the office visit charge only. Other Covered Expenses performed in the office are subject to the deductible and coinsurance.	1-15
Qualified Practitioner Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit Anesthesia: PPO deductible/100% to PPO coinsurance limit (for PPO and Non-PPO)	Inpatient and outpatient Hospital visits, surgery and anesthesia.	1-15
Oral Surgery	PPO Deductible/ 100% to PPO coinsurance limit (for PPO and Non- PPO)	Refer to list of covered oral surgeries in text. The Office Visit copay does not apply to this benefit.	1-16

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	<p>\$200 Plan: PPO: 100%, deductible waived</p> <p>Non-PPO: Deductible/80% to coinsurance limit</p> <p>\$1,200 Plan: 100%, deductible and coinsurance waived (for PPO and Non-PPO)</p> <p>Immunizations: 100%, deductible and coinsurance waived (for PPO and Non-PPO)</p>	<p>Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine prostate exams and routine immunizations.</p> <p><u>Refer to the text for details and limits.</u></p> <p>X-rays and Lab Tests: All covered x-rays and 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>Mammograms, Pap Smears & Endoscopic Surgeries (e.g. colonoscopies): Payable as shown under the Other Covered Expenses.</p> <p>Immunizations (Under Age 6 Years): Payable as shown under the Childhood Immunization Benefit.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-17
Outpatient Hospital Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-17
Emergency Room Benefit	<p>\$50 copay per visit/100% (for PPO and Non-PPO)</p> <p>The deductible is waived for this benefit.</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.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-17
Urgent Care Center Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all Covered Expenses performed during the visit.	1-18

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Ambulatory Surgical Center	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-18
X-ray and Laboratory Tests	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Dental x-rays limited to covered oral surgery or Injury. All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.	1-18
Diagnostic Tests Provided and Billed By an Independent Laboratory	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)		1-18
Ambulance Service Benefit	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.	1-18
Pregnancy Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	Covered for Employee, spouse and Dependent daughter. The Office Visit copay does not apply to this benefit.	1-18
Newborn Benefits	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	See "Section 3 – Eligibility" for important information on Dependent Coverage.	1-19
Birthing Center Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-19

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Home Health Care Benefit	100%, deductible and coinsurance waived (for PPO and Non-PPO)	40 visits per Calendar Year, when Home Health Care is in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home. If Your Qualified Practitioner indicates that You are terminally ill, another 40 Home Health Care visits are available each Calendar Year.	1-20
Convalescent Nursing Home Benefit	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	Limited to 30 days per Confinement.	1-21
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.	1-21
Human Organ and Tissue Transplants	PPO: Deductible/ 100% to PPO coinsurance limit Non-PPO: Not Covered (except for kidney transplants) <u>Kidney Transplant</u> Deductible 100% PPO or 80% Non-PPO to coinsurance limit	Procurement: Limited to \$10,000 paid per organ. (Refer to text for more details.) Refer to the list of covered transplants in the text. Pre-authorization of benefits is required for any transplant procedure. A request for pre-authorization may be submitted in writing to the Claims Administrator.	1-22
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other Sickness or Injury		1-23
Other Covered Expenses	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit		1-25

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	\$20 copay per visit/100% (for PPO and Non-PPO)	<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 applies to the office visit charge only. Other Covered Expenses performed in the office are subject to the deductible and coinsurance.</p> <p>Routine and maintenance care is not covered.</p>	1-25
Dental Treatment	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	<p>Refer to the list of Covered Expenses in the text.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-25
Physical, Speech, Occupational and Respiratory Therapy	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	<p>The Office Visit copay does not apply to this benefit.</p>	1-25
Outpatient Cardiac Rehabilitation	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	<p>Limited to Phase II only.</p> <p>Limited to three one-hour sessions per week, up to 12 weeks per covered Sickness.</p> <p>Refer to the text for details.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-26
TMJ Benefit	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	<p>Benefits include diagnostic, surgical and non-surgical treatment.</p> <p>Diagnostic and Non-Surgical Treatment: Limited to a combined maximum of \$1,250 paid per Calendar Year.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-26

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Routine Childhood Immunizations (State Mandate)	100%, deductible and coinsurance waived (for PPO and Non-PPO)	<p>Limited to Dependent children under the age of six years.</p> <p>Refer to the list if immunizations in the text.</p> <p>This benefit is in addition to any Wellness or Well Child Care benefit that may be part of this Plan.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-27
Mammograms	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine and those related to a Sickness.</p> <p>For any covered female person.</p>	1-27
Pap Smears	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine and those related to a Sickness.</p> <p>For any covered female person.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-27
Endoscopic Surgeries (e.g. Colonoscopies)	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine, those related to a Sickness and those requested due to family history.</p> <p>For any Covered Person.</p>	1-27

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Allergy Injections	Deductible/ 100% PPO or 80% Non-PPO to coinsurance limit	The Office Visit copay does not apply to this benefit.	1-27
Limitations and Exclusions	Not Payable	List of exclusions that apply to all Covered Expenses. A service that is normally covered may be excluded when provided with an excluded item.	1-31
Prescription Drug Card	100%, after copay Copays apply per drug/refill.	<p><u>\$200 PLAN</u> Retail (34-day supply per drug/refill) Generic: \$5 copay per drug/refill Brand: \$10 copay per drug/refill</p> <p>Mail Order (90-day supply per drug/refill) Generic: \$10 copay per drug/refill Brand: \$20 copay per drug/refill</p> <p>Out-of-Pocket Limit per Calendar Year:</p> <ul style="list-style-type: none"> ▪ Individual: \$250 ▪ Family: \$500 <p>Birth control is covered.</p> <p><u>\$1200 PLAN</u> Retail (34-day supply per drug/refill) Generic: \$10 copay per drug/refill Brand: \$20 copay per drug/refill</p> <p>Mail Order (90-day supply per drug/refill) Generic: \$20 copay per drug/refill Brand: \$40 copay per drug/refill</p> <p>Out-of-Pocket Limit per Calendar Year: \$250 per Covered Person. (This limit applies to Generic drugs only. It does not apply to Brand Name drugs.)</p> <p>Birth control is covered.</p>	1-35

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 that are a Covered Expense will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

4th Quarter Deductible Carryover Credit

Any Covered Expense Incurred during the last three months of the Calendar Year that is used to satisfy all or part of the deductible for that year, may be used to satisfy all or part of the deductible for the following Calendar Year.

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 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:

1. Penalties for failure to comply with the Utilization Review Plan; or
2. Benefit specific copays under the Plan.

NOTICE REQUIREMENTS

HOW THE PROGRAM WORKS

When You call UM, You will be asked the following questions:

- | | |
|---------------------------------|---|
| 1. Group name and number | 6. Patient's address |
| 2. Name of Employee | 7. Admitting facility and phone number, if applicable |
| 3. Employee's Social Security # | 8. Physician's name and phone number |
| 4. Name of patient | 9. Reason for admission or treatment |
| 5. Patient's birthday | 10. Admission or treatment date |

Once notice is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new notice must be made if: you do not receive the treatment within 30 days of the scheduled date; You use a different facility or physician; or *you* are admitted for a different reason.

NOTICE REQUIREMENTS

You or Your Qualified Practitioner are required to notify UM prior to receiving certain types of health care. The services that require prior notice are listed on the Schedule of Benefits. **If You are required to provide prior notice and fail to do so, benefits may be reduced or denied.**

NOTIFICATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY

If the provider is required to provide notice and it is not provided, You will not be subject to the non-compliance penalty. Your treatment will be reviewed when a claim is received.

If You are required to provide notice and it is not provided, Your treatment will be reviewed when a claim is received. If it is determined to be a Covered Expense, benefits that are otherwise payable will be reduced as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken after subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit.

If Your treatment is not a Covered Expense, no benefits will be payable under the Plan.

NOTICE SECONDARY COVERAGE WAIVER

If this Plan is secondary to another medical plan that also covers you, notification will not be required.

CASE MANAGEMENT

Case management services help You use Your benefits wisely during periods of treatment due to a serious Sickness or Injury. This is done through early identification of the need for case management in UM. Followed by on-going work with You and Your provider to plan health care alternatives to meet Your needs. The case manager will try to conserve Your benefits by making sure that Your care is handled as efficiently as possible.

The case management staff at UM consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to You, Your doctors and Your Employer, case management helps to control health care costs and use Your benefits wisely.

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 by the Hospital or separately:

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.
 - Inpatient visits are limited to one inpatient visit by a Qualified Practitioner other than the delivery Qualified Practitioner for a healthy newborn;
 - Consultation services when requested by the attending Qualified Practitioner are covered. This does not include staff consultations required by Hospital rules and regulations;
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.

If more than one surgery is performed during an operative session, the Covered Expense will be limited. The Usual, Customary and Reasonable (UC&R) fee for the primary surgical procedure will be payable. 50% of the UC&R fee for the secondary and following procedures will be payable.

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.

Surgical procedures include outpatient electroshock therapy, and injections of medication in lieu of surgery for ganglia, hernias and hemorrhoids.

No benefits are payable for incidental procedures, such as an incidental appendectomy.

Qualified Practitioner Benefits - continued

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.

ORAL SURGERY

Charges made for the following oral surgical procedures are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. Hospital or Ambulatory Surgical Center services are also covered.

1. Surgical exposure or removal of impacted teeth and related necessary x-rays;
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. Apicoectomy (excision of the apex of the tooth root);
5. Excision of exostoses of the jaws and hard palate;
6. Treatment of fractures of the facial bones;
7. External incision and drainage of cellulitis;
8. Incision or accessory sinuses, salivary glands or ducts;
9. Reduction of dislocations or, and excision or the temporomandibular joints;
10. Gingivectomy (excision of loose gum tissue to eliminate infection);
11. Alveolectomy (the leveling of structures supporting the teeth for the purpose of fitting dentures);
12. Frenectomy (incision of the mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue);
13. Removal of retained (residual) root;
14. Gingival curettage under general anesthesia; and
15. Apical curettage.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Covered Expenses include:

1. Routine physical exams;
2. Routine x-ray and laboratory tests;
3. Routine PSA tests and exams for any covered male person;
4. Routine immunizations;
5. Well child care services as prescribed by a Qualified Practitioner; and
6. Third party exams. Including, but not limited to, exams for employment, insurance, school, sports and camps.

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.

In addition to the general Limitations and Exclusions of the Plan, no benefits are payable under this Wellness Benefit for:

1. Medical examinations for Injury or Sickness;
2. Medical examinations caused by or related to a pregnancy;
3. Eye examinations for the purpose of prescribing corrective lenses;
4. Hearing tests;
5. Any dental examinations;
6. Mammograms. (These are payable under a separate benefit, as shown on the Schedule of Benefits.)
7. Pap smears. (These are payable under a separate benefit, as shown on the Schedule of Benefits.) or
8. Endoscopic surgeries (e.g. colonoscopies). (These are payable under a separate benefit, as shown on the Schedule of Benefits.)

OUTPATIENT HOSPITAL BENEFIT

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;
3. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by Your attending Qualified Practitioner; and

Outpatient Hospital Benefit - continued

4. Emergency room charges, but **only** if incurred due to:
 - a. Emergency Accident treatment,
 - b. a surgical procedure, including post-operative care, the removal of sutures, anesthesia and anesthesia supplies and services rendered by an employee of the Hospital, facility or other Qualified Practitioner other than the surgeon or assistant surgeon, or
 - c. treatment of a Sickness that is a medical Emergency.

URGENT CARE CENTER BENEFIT

Charges for Covered Expenses provided by an Urgent Care Center are payable as shown on the Schedule of Benefits.

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 any dental x-rays, unless related to a covered Injury.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service to a local Hospital are payable as shown on the Schedule of Benefits. The services must be used to or from a Hospital, Convalescent Nursing Home or sanitarium or from Your home or the scene of an Accident or medical Emergency. If You need care that is not available in a local Hospital, transport to the nearest Hospital that can provide the care is covered. If You require care that is not available by ground ambulance, air ambulance service to the nearest Hospital that can provide the care is covered.

PREGNANCY BENEFIT

Pregnancy is a Covered Expense for any covered female person. Covered Expenses are payable as shown on the Schedule of Benefits.

Complications of Pregnancy are payable, for any covered female person, as any other Sickness at the point the complication sets in.

Hospital and Qualified Practitioner services in performing therapeutic and elective abortions are a Covered Expense under this benefit.

Pregnancy Benefit - continued

Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (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. For information on precertification, contact Your Plan Administrator.

NEWBORN BENEFITS

This benefit does not apply unless You enroll Your newborn Dependent within 60 days of the date of birth. Please refer to Section 3 -- Eligibility of this Plan 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.

Well Newborn

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.

Sick Newborn

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 as shown in the Schedule of Benefits.

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.

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 aide 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;
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 consist 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; and
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.

Home Health Care Benefit - continued

Limitations

Home Health Care benefits do **not** include:

1. Food, housing, homemaker services or home-delivered meals;
2. Services not specifically listed above as a Home Health Care service;
3. Services or supplies not included in the Home Health Care plan established for you;
4. Services provided by Your immediate family or any other person residing with You; or
5. Services and supplied that are not required for the treatment of a Sickness or Injury.

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

Charges for these Hospice Care services are payable as shown on the Schedule of Benefits. Hospice Care must be in lieu of a covered Hospital or Convalescent Nursing Home Confinement.

1. Room and board and related services and supplies;
2. Part-time nursing care by or supervised by a registered nurse (R.N.);
3. Medical social services provided to You or Your immediate family. Services include:
 - a. assessment of social, emotional and medical needs, and the home and family situation, and
 - b. identification of the community resources available and assisting in obtaining those resources;
4. Dietary counseling;
5. Consultation and case management services;
6. Physical or occupational therapy;
7. Home Health Care and related supplies;
8. Part-time home health aide service; and
9. Medical supplies, drugs and medicines prescribed by a Qualified Practitioner.

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 Benefit - continued

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 of a social worker; 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. The attending Qualified Practitioner must certify that the transplant is required for the treatment of Your condition:

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;
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.

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

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.

Human Organ and Tissue Transplants - continued

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.

Benefits related to the procurement or transplant organs are subject to the limit shown on the Schedule of Benefits. This includes tissue typing, donor searches and surgical removal procedures, storage and transportation of the procured organs.

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; and
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.

Transitional Treatment Benefits

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

Transitional treatment means treatment 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 the chronically psychologically ill provided by a community support program; services for alcohol and chemical dependence 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.

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 lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

**Psychological Disorders, Chemical Dependence and
Alcoholism Benefit – continued**

Limitations

Benefits do **not** include:

1. Treatment of nicotine habit or nicotine addiction;
2. Marriage counseling; or
3. Court ordered examinations or counseling.

Covered Expenses are applied to the deductible, coinsurance and out-of-pocket limits shown on the Schedule of Benefits.

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.
2. Anesthesia services and supplies. Services must be rendered by a Qualified Practitioner who is not the operating surgeon or an assistant at the surgery; or by a registered nurse anesthetist. The services of a registered nurse anesthetist for nerve blocks used for analgesia are not covered.
3. Dental services rendered by a dentist for: (**Note:** Benefits for these dental services are not payable if there is coverage under the County's dental plan for such service.)
 - a. Extraction of seven or more natural teeth at one time,
 - b. Treatment of, and replacement of, natural teeth if the dental services are the result of an Accidental Injury. To be a Covered Expense under the Plan, the services must be incurred within 90 days of the date of the Accident. Damage resulting from biting or chewing will not be considered an Injury.
4. Services of a Hospital or Ambulatory Surgical Center due to dental care. To be a Covered Expense, the services must be 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 that requires hospitalization for such dental care, or
 - d. a Covered Person with a medical condition that requires general anesthesia, for such dental care.

Anesthetics related to the dental care will also be covered.
5. Treatment by a licensed: physical therapist; speech therapist; respiratory therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an Injury or Sickness, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders.
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. 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 of Sickness. Only those items that are approved as covered items under Medicare Part B are Covered Expenses. Repair expenses are covered, unless the damage results from Your negligence or abuse of such equipment. Maintenance expenses are not covered under this Plan.
7. Initial purchase of prosthetic appliances and supplies for the replacement of all or part of: a) an absent body organ (including contiguous tissue), or b) the function of a permanently inoperative or malfunctioning bodily organ. Replacement appliances are not covered. Repair and cleaning expenses are covered, unless the damage is the result of Your negligence or abuse of the appliance. Dental appliances are not covered.

Other Covered Expenses - continued

8. Outpatient Cardiac Rehabilitation. Limited to Phase II only. The program must begin within three months of a Hospital Confinement for myocardial infarction (a heart attack), coronary artery bypass graft, coronary angioplasty or another condition for which cardiac rehabilitation is appropriate for Your Sickness. Benefits are limited to three one-hour sessions per Covered Person, per week. Limited to a maximum of 12 consecutive weeks per Sickness.
9. Orthotic devices, including orthopedic braces and appliances.
10. Blood and blood plasma, except when replaceable by a blood donor club; administration of blood; blood processing fee charges to the Hospital by a blood bank or blood center.
11. Diabetic equipment and supplies, if they are not covered under the Prescription Drug Card. The installation and use of an insulin infusion pump. Diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before the initial purchase. (Certain diabetic equipment may be a Covered Expense under the durable medical equipment benefit.)
12. Special supplies when prescribed by Your attending Qualified Practitioner and necessary for the continuing treatment of a Sickness or Injury.
13. Temporomandibular Joint (TMJ) surgical, non-surgical and diagnostic treatment. Benefits include prescribed intraoral splint therapy devices. Diagnostic and non-surgical treatment is subject to the limits shown on the Schedule of Benefits. Benefits include appliances and therapy for any jaw joint problem, including any temporomandibular joint disorder, craniomaxillary or craniomandibular disorder or other conditions of the jaw joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof, including headaches. These Covered Expenses do not include cosmetic or elective orthodontic care, periodontal care or general dental care.
14. Blood lead tests for covered Dependent children under the age of six years. Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.
15. Outpatient radiation therapy.
16. Chemotherapy.
17. Pre-admission testing required in connection with an inpatient Hospital admission for surgery. Pre-admission testing must be performed within seven days of a covered inpatient Confinement for surgery and accepted by the inpatient facility in lieu of like tests performed after Your admission. The tests may be performed in either a Qualified Practitioner's office or the Outpatient department of a Hospital.

If You or the Qualified Practitioner unexpectedly cancel the inpatient admission, services for pre-admission testing will be paid as an Outpatient Hospital claim, provided the services are properly identified as pre-admission testing.

Other Covered Expenses - continued

18. Routine childhood immunizations. For a covered Dependent child from birth to the age of six years. Payable as shown on the Schedule of Benefits. This benefit is in addition to any Wellness or Well Child Care benefit that may be part of this Plan. Including, but not limited to, the following immunizations:
 - a. Diphtheria,
 - b. Pertussis,
 - c. Tetanus,
 - d. Polio,
 - e. Measles,
 - f. Mumps,
 - g. Rubella,
 - h. Hemophilus influenza B.,
 - i. Hepatitis B.,
 - j. Varicella,
 - k. Human papillomavirus (HPV) vaccine
19. Mammograms. Includes routine and those related to a Sickness. For any covered female person.
20. Pap smears. Includes routine and those related to a Sickness. For any covered female person.
21. Endoscopic surgeries (e.g. colonoscopies). Includes routine, those related to a Sickness and those requested due to family history. For any Covered Person.
22. Allergy injections.
23. Expenses 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).
24. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:
 - a. reconstruction of the breast that was removed,
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
 - c. prostheses to replace the breast that was removed, and
 - d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the Plan.
25. Hearing aids, cochlear implants and related treatment for a covered Dependent child under the age of 18 years old, if the child is certified as deaf or hearing impaired by a Qualified Practitioner or audiologist. This benefit is not subject to the Pre-Existing Conditions limitation. Covered Expenses include:
 - a. the cost of hearing aids and cochlear implants that are prescribed by a Qualified Practitioner or audiologist, in accordance with accepted professional medical or audiological standards,
 - b. the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices,
 - c. One hearing aid per ear every three Calendar Year.

Other Covered Expenses - continued

26. Birth control, when not covered by the Prescription Drug Card. Covered expenses include but are not limited to birth control pills, implants, injections, intrauterine devices (IUDs), cervical caps, and diaphragms. You must obtain a prescription from your Qualified Practitioner or other licensed health care professional. The Medical Plan also covers related charges such as consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive. The Plan does not cover drugs, services or supplies that can be obtained without a prescription from a Qualified Practitioner or other licensed health care professional, such as condoms and contraceptive foam or gel. **(Note: Birth control that is covered under the Prescription Drug Card is not a Covered Expense under the Medical Plan.)**
27. Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and nonintensive-level services.

Intensive-level services means evidence-based behavioral therapies that is designed to help a Covered Person with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

Nonintensive-level services means evidence-based therapy that occurs after the completion of treatment for intensive-level services or, for a Covered Person who has not and will not receive intensive-level services, evidence-based therapy that will improve the Covered Person's condition.

Intensive Level Services

Benefits are provided for evidence-based behavioral intensive-level therapy for a Covered Person with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the Covered Person when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- a. based upon a treatment plan developed by a Qualified Practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,
- b. implemented by Qualified Practitioners, qualified supervising provider, qualified professional, qualified therapists or qualified paraprofessionals,
- c. provided in an environment most conducive to achieving the goals of the Covered Person's treatment plan,
- d. included training and consultation, participation in team meeting and active involvement of the Covered Person's family and treatment team for implementation of the therapeutic goals developed by the team,
- e. commenced after a Covered Person is two years of age and before nine years of age,
- f. the Covered Person is directly observed by the Qualified Practitioner at least once every two months.

Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the Covered Person, regardless of payor, may be applied to the required four years. The Plan may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for autism spectrum disorders prior to age nine.

Travel time for Qualified Practitioners, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week.

Other Covered Expenses - continued

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for a Covered Person with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to a Covered Person by a Qualified Practitioner, professional, therapist or paraprofessional in either of the following conditions:

- a. after the completion of intensive-level services and designed to sustain and maximize gains made during intensive level services treatment,
- b. to a Covered Person who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Covered Person's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- a. based upon a treatment plan developed by a Qualified Practitioner, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,
- b. implemented by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified therapist or qualified paraprofessionals,
- c. provided in an environment most conducive to achieving the goal of the Covered Person's treatment plan,
- d. included training and consultation, participation in team meetings and active involvement of the Covered Person's family in order to implement the therapeutic goals developed by the team,
- e. provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by Qualified Practitioners, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Travel time for Qualified Practitioners, qualified supervising providers, qualified professional, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan will notify the Covered Person (or their authorized representative) if the level of treatment is transitioning from intensive-level services to nonintensive-level services. The notice will indicate the reason for transition that may include any of the following:

- a. the maximum four-year limit has been met,
- b. intensive-level services are no longer supported by the documentation provided by the Qualified Practitioner;
- c. the Covered Person no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

Other Covered Expenses - continued

Intensive-level and nonintensive-level services include but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under the autism spectrum disorders:

- a. acupuncture,
- b. animal-based therapy including hippotherapy,
- c. auditory integration training,
- d. chelation therapy,
- e. child care fees,
- f. cranial sacral therapy,
- g. custodial or respite care,
- h. hyperbaric oxygen therapy,
- i. special diets or supplements,
- j. pharmaceuticals and durable medical equipment.

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, and hypnotherapy; or
2. **Acupuncture** therapy.

DENTAL

1. **Dental care** or treatment, except as specifically described; or for orthognathic surgery, including osteotomy procedures of the maxilla and 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; or
2. Charges for **prescription drugs**, except when not covered by the County'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.

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, unless for reconstructive surgery due to Injury, infection or other disease of the involved; or due to congenital disease or anomaly which resulted in a functional defect; or due to a previous therapeutic process;
2. Any charges for, relating to or resulting from **sex change operations**; or
3. Any treatment or services for **weight control or reduction**. 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; or any obesity surgery, including, but not limited to stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy. Note: This exclusion does not include gastrointestinal surgery for morbid obesity. Morbid obesity is defined as having a Body Mass Index of 40 or greater.

PRE-EXISTING CONDITIONS

1. Pre-Existing conditions, to the extent specified in the Definitions section.

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**;
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; Charges which are not documented in provider records; additional charges for services requested after normal provider service hours or on holidays;
4. **Private duty nursing**, except as specifically stated; or
5. **Services, supplies or equipment prescribed by or performed by a/an: a) Masseur or masseuse (massage therapist), b) Midwife, except a Nurse Practitioner, c) Physical therapist technician, d) hearing aid dealer or fitter (except as specifically described under the Other Covered Expenses, e) Social Worker, or f) Audiologist (except as specifically described under the Other Covered Expenses.** (Note: Certain hearing aids, cochlear implants and related treatment are payable as specifically described under the Other Covered Expenses.)

REPRODUCTION

1. 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. (Note: Diagnostic testing up to the original diagnosis of infertility is a Covered Expense. Once the initial diagnosis of infertility is determined, no additional infertility testing will be covered.);

Limitations and Exclusions - continued

2. Treatment, services or supplies for a **surrogate mother** or any pregnancy resulting from Your service as a surrogate mother;
3. Treatment of a **sexual dysfunction** not related to organic disease, including, but not limited to sexual counseling or therapy, implants and hormonal therapy;
4. **Genetic testing or counseling**, unless required to treat the Sickness or Injury of a Covered Person or used in the treatment of a high risk pregnancy; or
5. The **reversal of sterilization** procedures.

ROUTINE AND GENERAL HEALTH

1. **Eye refractive disorders, vision therapy** (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, hearing aids (except as specifically stated for hearing aids or cochlear implants) or the examination, fitting or repair of any hearing aid or eyeglasses. The initial purchase of eyeglasses or contact lenses for aphakia, keratoconus and after a cataract surgery is a Covered Expense. (Note: Certain hearing aids, cochlear implants and related treatment are payable as specifically described under the Other Covered Expenses.)
2. **Health check-ups or routine exams and immunizations**, except as stated; **prophylactic surgery** to prevent a Sickness that has not occurred yet, unless required by law; or **third party exams**, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment, school, travel or the purchase of insurance; unless specifically stated as a Covered Expense; or
3. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction.

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 or pre-notification 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);
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; or

Limitations and Exclusions - continued

6. **Any services, supplies or equipment which are required to be provided by a public school district or state or local educational agency** pursuant to the requirements of the federal Individuals with Disabilities Act, 20 U.S.C. subsection 1401 et. Seq., as amended, or any state or local laws and regulations which implement such act. This exclusion applies whether or not the service is actually provided by the public school district or educational agency.

OTHER

1. Charges **in excess of the Usual, Customary and Reasonable charge** for the service or supply;
2. Any service or supply that does **not** meet the Plan's guidelines for Clinical Eligibility for Coverage;
3. **Custodial care; rest cures; travel for health;**
4. Any medical expense incurred **before Your effective date** of coverage under this Plan or **after the date Your coverage under the Plan terminates**, except as specifically described;
5. Charges incurred **outside the United States** if You traveled to such location to obtain the service, drug or supply;
6. Any loss caused or contributed to by:
 - a. **war or any act of war**, whether declared or not, or
 - b. any act of international armed conflict, or any conflict involving armed forces of any international authority;
7. 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 otherwise for the treatment of Autism Spectrum Disorders;
8. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;
9. Inpatient Hospital admissions which are primarily for physical, speech or occupational therapy or for x-ray or radiation therapy;
10. Services or supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, academic institution or similar person or group;
11. Personal hygiene or convenience items, including air conditioners, humidifiers and physical fitness equipment;
12. Charges for **passive Confinement for rest or study in a Christian Science Sanitarium;**
13. **Federal, state or local tax** on goods and services;
14. **Sub-acute or transitional care**, unless provided or rendered in a Convalescent Nursing Home or mental health section of a Hospital or mental health facility; or
15. Any service or supply 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 (e.g. the Cancer Clinical Trial benefit).

PRESCRIPTION DRUG CARD

Your Medical identification (ID) card is also Your Prescription Drug ID card.

A directory of participating pharmacies is available on the Drug Card's web site. The directory contains the name, address and telephone number of the pharmacies that are part of the Drug Card program.

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.

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 County.

Mail Order Drug Service

If You are using an ongoing 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 web site or from the County. All prescriptions will be mailed directly to Your home.

SECTION 2 DEFINITIONS

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the Plan. Defined words are capitalized throughout the Plan.

Accident

A happening by chance and without intention or design. A happening, 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 County and meets the minimum requirements set by the County for eligibility under the Plan. 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 County 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.

Definitions – continued

Calendar Year

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

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.

Clinical Eligibility for Coverage

Services required to diagnose or treat an Injury or Sickness. Services must be known to be safe, effective and appropriate by most Qualified Practitioners who are licensed to treat that Injury or Sickness. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the Injury or Sickness. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the Qualified Practitioner.

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 of Pregnancy do not include: false labor; occasional spotting; prescribed rest during the pregnancy; morning sickness or similar conditions associated with the management of 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. Confinement starts upon Your admission to a Hospital and ends with Your discharge. Successive Confinements are considered one if:

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

Definitions – continued

Convalescent Nursing Home (Skilled Nursing Facility or Extended Care Facility)

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.

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 or prior Convalescent Nursing Home 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 certified the required Convalescent Nursing Home Confinement.

County

The County or other governmental unit, identified on the cover page, which employs the Covered Employee.

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.

Definitions – continued

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.

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 unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

The limiting age for each Dependent child is the end of the Calendar Year in which such child reaches age 27, provided such child is not married **and** is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a dependent under the this plan).

Coverage may be extended (beyond age 27) for a Dependent child if **all** of the following requirements are met:

- a. The Dependent child is a full-time student, regardless of age, and
- b. the Dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a Dependent under the Employee), and
- c. the Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. the Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

1. the date the child's coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

Definition of Dependent - continued

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

3. A covered Employee's grandchild. The parent of the child must be a covered Dependent child who is not yet 18 years old for the grandchild to be covered.

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 or physically handicapped;
2. The child is incapable of self-sustaining employment because of the 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 annual 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.

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.

Employee

You when You are: regularly employed by the County.

Employer

Sawyer County, which employs the Covered Employee.

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 the effective date of Your coverage under this Plan.

Definitions – continued

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, child, parent, grandparent, brother or sister, or 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.

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.

Definitions – continued

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.

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.

Definitions -- continued

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.

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.

Definitions - continued

Inpatient Treatment

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

Late Applicant

An Employee who enrolls for coverage more than 31 days after they are eligible to be covered. A Dependent who is enrolled for coverage more than 31 days (60 days for a newborn child or an adopted child) after they are eligible to be covered.

Lifetime

When used in reference to benefit maximums and limitations, the time You are covered under this Plan, whether or not Your coverage under the Plan is continuous. In no circumstances does Lifetime mean Your life span.

Medical Condition

A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

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.

Definitions – continued

Pre-Existing Condition

This applies to Late Applicants Only. A Sickness or Injury is pre-existing if You received treatment or drugs for it during the six-month period immediately prior to Your Enrollment Date. Treatment includes the initial diagnosis of the condition.

Pre-Existing conditions are covered after the end of a period of 18 month from Your Enrollment Date.

Pre-Existing Condition Exceptions

The exclusion will not apply:

- a. to any Covered Expense due to pregnancy,
- b. 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,
- c. 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
- d. 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.

Definitions - continued

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.

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 County. 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.

Urgent Care Center (Walk-In Clinic)

A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. Urgent Care Center does not include a Hospital or Emergency room.

Usual, Customary and Reasonable

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.

1. If more than one surgery is performed during an operative session, the Covered Expense will be limited. The Usual, Customary and Reasonable (UC&R) fee for the primary surgical procedure will be payable. 50% of the CU&R fee for the secondary procedure will be payable. 50% of the CU&R fee for the third and following procedures will be payable.
2. The CU&R fee for an assistant surgeon or physician's assistant is based on the CU&R fee for the primary surgeon as follows: 16% for an assistant surgeon; and 14% for a physician's assistant.

In the case of a PPO Provider, it will mean 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.

SECTION 3 ELIGIBILITY

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to Employees hired on or after the effective date of this Plan. The Dependent Coverage section applies to Dependents that are added on or after the effective date of this Plan.

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 the Plan.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the Plan if the following conditions are met:

1. You are an Employee who meets the eligibility requirements of the County; and
2. You satisfy an eligibility period of 30 consecutive days of regular employment with the County.

You are eligible to be covered on the first day of the month after You complete the eligibility period. 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 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 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 active work with the County 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 court order places a child in the Employee's home. The child must be under the Employee's legal guardianship;
5. The date a child is legally adopted; or
6. The date a valid court order is issued which, by federal law or Plan provision, requires the Plan to provide coverage.

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 OF COVERAGE

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 day of the month 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 child who becomes an Employee must apply for coverage as an Employee to remain covered by the Plan. The child will not be eligible as Your Dependent.

RETIREE COVERAGE

If You are at least age 55 (52 for the Sheriff's Department) and You have at least 15 years of service with the County, You may be eligible for Retiree Coverage for Yourself and any eligible Dependents. Retiree Coverage will end on the date You become Medicare-eligible, whether You elect Medicare or not. At that time, coverage will also end for any Dependents of the Retiree. The Retiree must pay the full cost of Plan contributions.

When Retiree Coverage ends, COBRA Continuation will be offered to any eligible person.

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 or individual health coverage, or COBRA continuation, and coverage under that 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;
4. Ends Employer contributions towards the cost of the other coverage;
5. The amount of premiums Your spouse is required to pay, for covered under the spouse's plan, goes up by at least 25% of the family plan rate; or
6. The amount of contribution You are required to pay for coverage under this Plan goes down by at least 25% of the family plan rate.

Then a special enrollment event has occurred. At that time, an Employee or Dependent may be enrolled 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;
2. When a Dependent has a loss of coverage, only that Dependent and the Employee may enroll. The Employee does not have to have had a loss of coverage at that time to enroll. Other Dependents that did not have a loss of coverage will be considered Late Applicants.

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.

Special Enrollment Rights - continued

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 may also be enrolled at this time. Any other Dependents that were not previously covered under the Plan will be considered Late Applicants.

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 will be considered Late Applicants.

You must enroll in this Plan within 31 days (60 days for a newborn child or an adopted child) 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 (60 days for a newborn child or an adopted child) after the date of such an event, it will be considered Late Enrollment under this Plan.

MEDICAID/STATE CHILD HEALTH PLAN

If You and/or Your Dependents were covered under a Medicaid plan or State child health plan and Your coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this Plan within 60 days after the date of termination of such coverage. Coverage under this Plan will be effective on the date the other coverage ends.

If You apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, You will be considered a Late Applicant under this Plan.

Premium Assistance

Current Employees and their eligible Dependents may be eligible for a special enrollment event if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or State child health plan, for premium assistance with respect to coverage under this Plan. You must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance. If You apply for coverage more than 60 days after this date, You will be considered a late Applicant under the Plan.

SPOUSAL TRANSFER PROVISION

If both spouses are Employees and each has taken single coverage under this Plan, this Plan permits Your spouse to take coverage as Your Dependent at any time.

Spousal Transfer Provision – continued

In addition, if both spouses are Employees and eligible for coverage under this Plan and Your spouse previously waived coverage as an Employee in favor of coverage as Your Dependent, this Plan permits Your spouse to take coverage as an Employee under the Plan and to enroll You and any other eligible Dependents as Dependents of Your spouse when:

1. You and Your spouse decide to transfer coverage under the Plan from one spouse to the other;
2. Your spouse decides to take coverage as an Employee for any reason; or
3. You terminate Your coverage under the Plan for any reason.

Your spouse must elect coverage under this Plan within 30 days of the date Your coverage ends to be a timely enrollment. Your spouse's coverage under this Plan will be effective on the day Your coverage ends.

If Your spouse applies more than 31 days after the date Your coverage ends, You will be Late Applicants under the 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 90 days of a termination of employment, Your coverage will be effective on the day You return to work. The eligibility period (if any) will be waived with respect to the reinstatement of Your coverage. The pre-existing condition exclusion will be waived to the extent it was already satisfied.

If You return to work more than 90 days after Your termination date, You will be considered a new Employee and will be subject to all Plan provisions.

If Your coverage was converted, Your conversion policy ends on the date Your coverage is reinstated.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. For any benefit, the date the benefit is removed from the Plan;
3. The end of the period for which any required Employee or County contribution was due and not paid;
4. The date You enter the full-time military, naval or air service of any country;
5. The last day of the month following the month in which You cease to be eligible according to the eligibility requirements of the County;
6. For all Employees, the last day of the month following the month in which You receive Your final payroll check from the County;
7. For all Retired Employees, the last day of the month following the month You receive Your final payroll check from the County, unless You are eligible for, and elect, Retiree Coverage;
8. For a Dependent, the date the Employee's coverage terminates;
9. For a Dependent, the date that Dependent no longer meets this Plan's definition of a Dependent;
10. For a Dependent, the date the Dependent enters the full-time military, naval or air service of any country;
11. For an Employee's spouse, the date of entry of a judgment of divorce or annulment of the marriage;
12. The date You request termination of coverage to be effective for Yourself and/or Your Dependents; or
13. The date You die. (If the Covered Employee dies, such Employee's Covered Dependents (spouse and children) may remain covered under this Plan until the last day of the month in which the Covered Employee died.)

Important Notice for Active Employees and Spouses Age 65 and Over

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 the County for further information.

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, Your coverage will be effective on the same date it would have been had You not taken leave. If the Plan is amended 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 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.

TYPES OF LEAVE

Coverage under this Plan can be continued during a period of FMLA leave. The Employee must continue to pay the Employee portion of the Plan contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the Employer, for:

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;
4. The Employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or
5. Any qualifying necessity that results from the Employee's spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the Employer, to care for a member of the armed forces that is the Employee's spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

FMLA - continued

Maximum Leave Period

The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the Employee and the Employee's spouse are both employed by the Employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;
2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or
3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

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.

DEFINITIONS

For this provision only, the following terms are defined as shown 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;

FMLA - continued

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.

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 the County.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this Plan be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the Plan to similar active Employees. This means that when coverage is changed for similar active Employees it will also change for the person on leave. The cost of such coverage will be:

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

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

Coverage provided due to this Act will reduce any coverage required by 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 after completion of Your 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.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon Your return to work. Reinstatement will apply whether coverage under the Plan was maintained during the leave or not. To be eligible for reinstatement You must be honorably discharged from the military service and return to work within:

1. The first, full business day after Your military service ends, 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 after Your military service ends, for leaves of 31 to 180 days;
3. 90 days after Your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if Your military service: causes a Sickness or Injury; or worsens a Sickness or Injury. Your failure to return within the times stated must be due to such a Sickness or Injury. In that case, You may take up to a period of two years to return to work. If for reasons beyond Your control You cannot return to work within two years, You must return as soon as is reasonably possible.

USERRA - continued

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

This does not waive the Plan's limits on Sickness or Injury: caused by Your military service; or worsened by Your military service. The Secretary of Veterans Affairs will determine if Your military service caused or worsened a Sickness or Injury.

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

CONTINUATION 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;
5. The Employee becoming entitled to Medicare; or

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COBRA – continued

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 the 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.

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.

COBRA - Continued

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.

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.

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COBRA – continued

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.

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.

ARRA made several amendments to the Trade Act of 2002, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered Employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

COBRA – continued

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.

AMERICAN RECOVERY AND REINVESTMENT ACT

Note: This provision will automatically terminate on December 31, 2011, and benefits outlined will no longer be available without further Plan amendment.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act of 2010 ("Defense Act"), the Temporary Extension Act of 2010 ("TEA"), the Continuing Extension Act of 2010 and any future applicable legislation, reduces the COBRA premium in some cases. If a Covered Person experienced a Loss of Coverage due to involuntary termination by the Employer during the period that begins with September 1, 2008 and ends with May 31, 2010, the Covered Person may be eligible for the temporary premium reduction for up to 15 months.

ELIGIBLE INDIVIDUALS

Covered Persons and their Dependents who experienced a Loss of Coverage under the Plan due to an involuntary termination of employment between September 1, 2008 and May 31, 2010 or is an individual who experiences a Qualifying Event that is a reduction of hours occurring at any time from September 1, 2008 and May 31, 2010, which is followed by an involuntary termination of employment on or after March 2, 2010 through May 31, 2010 and as a result, fit the definition of Qualified Beneficiary under COBRA are eligible. These individuals may also be referred to as Assistance Eligible Individuals (AEIs).

COBRA - continued

Some AEIs will have declined COBRA prior to passage of the law or elected COBRA but then dropped coverage prior to passage of the law. These AEIs will have a second opportunity to elect COBRA coverage and take advantage of the premium subsidy (reduced premium).

Some AEIs who have exhausted their nine month subsidy period prior to December 19, 2009 and who failed to pay the premium during the transition period may be eligible to retroactively reinstate coverage provided that they pay the reduced premium for such coverage within 60 days of the date of the enactment (in which case the due date would be February 17, 2010) or if later, 30 days after the date the notice is provided. The transition period is any period of coverage that begins prior to December 19, 2009 and is subject to the extension.

In addition, any AEI who exhausted their nine month subsidy period prior to the date of enactment of the "Defense Act", and then subsequently paid the full premium during the transition period (the period of coverage that begins prior to December 19, 2009) are entitled to a refund or credit as prescribed by the original ARRA legislation.

An AEI that is eligible for the subsidy as a result of a reduction of hours that is followed by an involuntary termination of employment will have his or her maximum COBRA coverage measured from the date of the reduction in hours. This means that upon the later involuntary termination of employment, the individual can elect COBRA coverage only for the remainder of the original COBRA coverage period which began upon the reduction of hours of employment. Please refer to Your COBRA election form for additional information regarding Your rights to COBRA.

Assistance Eligible Individuals must not be eligible for coverage under any other group health plan (other than certain limited plans). This includes eligibility for coverage under a spouse's employer's plan or Medicare. Failure to notify the Plan of eligibility under any other group health plan can result in significant penalties.

The subsidy will be phased out starting with taxpayers whose modified adjusted gross income exceeds \$125,000 (\$250,000 in the case of a joint return). This means a percentage of the subsidy will be recaptured in the federal income taxes imposed on individuals making more than \$125,000 (\$250,000 in the case of a joint return). Higher income individuals (\$145,000 (\$290,000 in the case of a joint return) can make an election to waive the subsidy in the manner and form set forth by the Secretary of the Treasury.

AMOUNT AND LENGTH OF SUBSIDY

Assistance Eligible Individuals will be responsible for only 35% of the amount of their COBRA premium. That means a Qualified Beneficiary whose normal full COBRA premium would be \$500 per month would be responsible for paying only \$175 per month for the qualifying time period.

The subsidy period ends at the earliest following date:

- Fifteen months after the date the individual becomes eligible for the subsidy;
- The Qualified Beneficiary becomes eligible for coverage under any other group health plan (other than certain limited plans) or becomes eligible for Medicare. This also includes eligibility for coverage under a spouse's employer's plan. The Qualified Beneficiary must notify the administrator in writing of such eligibility as set forth by the Department of Labor (DOL). Failure of the Qualified Beneficiary to notify the administrator may result in a penalty of 110% of the premium reduction provided after termination.

COBRA - continued

- The Qualified Beneficiary's maximum period of continuation coverage required under the applicable COBRA continuation coverage provision is met. Note that for those Qualified Beneficiaries receiving a second opportunity to elect coverage, the maximum COBRA continuation coverage period runs from the original Qualifying Event.

ELECTING THE SUBSIDY

If You have a Qualifying Event between September 1, 2008 and May 31, 2010, Your COBRA Administrator will send You a formal notification of Your COBRA rights under the American Recovery and Reinvestment Act, as amended. The notification will include the necessary forms and instructions on how to elect to receive the subsidy as applicable.

If it is determined that You are not an AEI, and You disagree with this determination, You may appeal this determination with the Department of Labor (DOL) in the manner and form specified by them. Please see <http://www.dol.gov/ebsa/subsidydenialreview.html>. State and local government Employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

ELECTING DIFFERENT COVERAGE

If Your Plan offers a lower cost option, Assistance Eligible Individuals have the option to elect enrollment in the less expensive coverage than what the individual was enrolled in at the time the Qualifying Event occurred, if such coverage is generally available to current employees. If the Employer offers this option, the notification that You will receive in the next few weeks will include information on the plans that are available and explain the procedure for enrolling in different coverage. If an AEI chooses to enroll in different coverage, such coverage shall be treated as COBRA continuation coverage.

In order for the Qualified Beneficiary to be eligible to elect different coverage than what they were enrolled in at the time of the Qualifying Event, all of the following must apply:

1. The premium for different coverage cannot be more than the premium for the coverage the individual was enrolled in when the qualifying event occurred;
2. The different coverage must also be offered to active employees at the time the election is made;
3. The different coverage cannot be coverage that provides only:
 - a. dental, vision, counseling or referral services (or a combination of such services),
 - b. a flexible spending account,
 - c. coverage for services or treatments furnished in an on-site medical facility maintained by the Employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or combination of such care).

This election must be made in writing and not more than 90 days after the date of *your* formal COBRA notification.

If You have any questions about *your* rights to COBRA continuation coverage, You should contact Your COBRA administrator.

INDIVIDUAL MEDICAL CONVERSION PRIVILEGE

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, You may continue group coverage until:

1. The individual on continuation coverage establishes residence outside this state that the Employer is located in;
2. The individual on continuation coverage fails to make a timely payment of a required premium amount;
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 no longer eligible for coverage by the Plan; or
4. The individual on continuation coverage becomes eligible for similar coverage under another plan.

The Conversion Carrier sets the type of coverage and benefits that will be offered. Benefits provided under conversion may differ from those of this Plan.

SECTION 4 GENERAL PLAN INFORMATION

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This Plan's benefits are coordinated with benefits provided by other plans that cover You. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this Plan. This provision will apply whether or not You file a claim under any other plan that covers You.

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.

Definitions

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. Such contracts may be obtained due to the Covered Person's membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

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 Expense. These plans are called secondary plans.

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

Order of Benefit Determination

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.
2. The plan that covers the person as an Employee will be primary.

Coordination of Benefits - continued

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar Year will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary. 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.

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. If a plan other than this Plan does not include a provision similar to this one, then this provision will be ignored to coordinate benefits with the other plan.
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.

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 between Medical and Dental Plans

If a service is covered under the Medical Plan and a Dental Plan, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits – continued

Coordination of Benefits with Medicare

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Your benefits under this Plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they 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.

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.

Workers' Compensation

This Plan excludes coverage for any Injury or Sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the Plan and You receive Workers' Compensation for the same incident, the Plan has the right to recover. That right is described in this section. The Plan reserves its right to exercise its recovery rights against You even though:

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

GENERAL PROVISIONS

The following provisions are to protect Your legal rights and the legal rights of the Plan.

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 County at any time. The Plan may be terminated by the County at any time. Any changes to the Plan will be communicated immediately by the County 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 if the provider will refund any payments made in error. The Plan does not attest to the legal validity or effect of any assignment.

CLAIM REVIEW PROCEDURE

The rules stated in this section shall be followed by all persons and entities seeking review of any decision as to eligibility for benefits or the amount of benefits paid. These rules shall be the exclusive remedy for any such decision, except as otherwise required by applicable law.

Request for Review

Any participating Employee or beneficiary who has been affected by a decision to deny a claim for benefits, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after the mailing of a written notice of the denial of the claim or of the amount of the benefits to be paid. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

Claim Review Procedure Provision - continued

Review

On timely receipt of a request for review, the Claims Review Committee shall schedule a review within **sixty (60) days** of receipt of the request. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims.

Decision

The Claims Review Committee shall issue a written decision within **ten (10) days** after the end of the review, affirming, modifying or setting aside the previous decision or action. The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

To submit a request of claim review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee
WCA Group Health Trust
22 East Mifflin Street, Suite 900
Madison, WI 53703

CLERICAL ERROR

A clerical error by the County, 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 part 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 County and Covered Employees. The County sets the amount of the Employee contribution. The County reserves the right to adjust or modify such contributions. All Employee contributions are on a non-discriminatory basis.

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.

General Provisions – continued

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 claims, whichever is earlier. You cannot bring action more than three years after proof of loss is required.

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 by 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 any one or more of the following: Your estate; Your spouse; Your Dependent children; Your parents; or 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.

Privacy of Protected Health Information - continued

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.
- 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.

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.

Privacy of Protected Health Information - continued

- 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").
- 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.

Privacy of Protected Health Information - continued

- 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.

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 provide the Plan with written proof of Your claim. Proof should be provided as soon as reasonably possible. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless You were legally incapacitated during the period, any claim received by the Plan more than 15 months after the date the claim was incurred will not be covered under the Plan.

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. Any attempt to accomplish these will be void. If the Plan Administrator finds that such an attempt has been made, it, at its sole discretion, may terminate Your interest in the payments. The Plan will then apply the amount of the payment to 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.

General Provisions - continued

REPRESENTATIONS

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

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.

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;
2. Require that any agent or subcontractor of the Trust agrees to the same requirements that apply to the Trust 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 CLAIM DETERMINATION

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

AMENDMENT #1

WCA Group Health Trust -- Sawyer County
Group Number: WCA 0058

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE MARCH 31, 2010.

Under the definition of "Dependent", Item #2 is deleted and replaced with the following:

2. A covered Employee's married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

A married or unmarried Dependent child may be covered until the end of the Calendar Year in which such child reaches age 26. (Note: Dependent children who are working and eligible for benefits under their own employer (or their spouse's employer) are not eligible for coverage under this Plan, unless the cost of their own employer's coverage (or their spouse's employer's coverage) is more expensive than the cost for coverage as a Dependent under this Plan.

After age 26, an unmarried Dependent child may be covered until the end of the month in which such child reaches age 27, provided such child is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a Dependent under the this Plan).

Coverage may be extended (beyond age 27) for a Dependent child if **all** of the following requirements are met:

- a. The Dependent child is a full-time student, regardless of age, and
- b. The Dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a Dependent under the Employee), and
- c. The Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. The Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

1. the date the child's coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

Under the definition of “Dependent”, the following language is added to the Plan:

~~Dependent Child One Time Special Open Enrollment Period~~

From November 15, 2010 to December 15, 2010, this Plan will provide a Dependent Child One Time Special Open Enrollment Period for Dependent children who have not yet reached the limiting age under this Plan. An eligible Employee who is not covered under this Plan may also enroll at this time, if such enrollment is required to enroll the Dependent child on the Plan. During this Dependent Child One Time Special Open Enrollment Period, Employees who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

The Plan Administrator must receive the completed enrollment form and any applicable Plan contribution within the Dependent Child One Time Special Open Enrollment Period. If You do not apply within the Dependent Child One Time Special Open Enrollment Period, You will be considered a Late Applicant under this Plan. If a Dependent child experiences a change in status at a later date, coverage will be provided as stated in the Special Enrollment Rights section of this Plan.

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2011.

On pages 1-3 and 1-4, the \$200 Plan section of the Schedule of Benefits is deleted and replaced with the following “General Plan” benefits:

General Plan

MEDICAL BENEFITS (General Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Calendar Year			The amount You must pay each year before the Plan will begin paying any benefits.	1-13
PPO				
Individual	\$0	\$200	PPO and Non-PPO Employee +1 and Family maximums are on an aggregate dollar basis.	
Employee +1	\$0	\$400		
Family	\$0	\$600		
Non-PPO				
Individual	\$0	\$200		
Employee + 1	\$0	\$400		
Family	\$0	\$600		
Individual Coinsurance per Calendar Year			After the deductible, the coinsurance amounts shown above apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-13
Plan 1 (Others)				
PPO	100%	0%		
Non-PPO	70%	30%		
Plan 2 (Highway)				
PPO	100%	0%		
Non-PPO	80%	20%		

MEDICAL BENEFITS (General Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Out-of-Pocket Limit per Calendar Year PPO			Represents the total paid by You for the deductible and coinsurance. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-13
Individual Employee +1 Family		\$200 \$400 \$600	PPO and Non-PPO Employee + 1 and Family maximums are on an aggregate dollar basis.	
Non-PPO Individual Employee +1 Family		\$700 \$1,400 \$1,600	Your out-of-pocket expense for a Calendar Year will never exceed the Non-PPO out-of-pocket limit.	

All Covered Expenses under the Plan are payable at the Plan's Usual, Customary 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 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.

On pages 1-6 through 1-12, the Covered Expenses section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	Subject to the deductible and coinsurance	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-15
Qualified Practitioner Office Services Benefit	\$20 copay per visit/100% (for PPO and Non-PPO)	This copay does not apply to the out-of-pocket limits. The deductible and coinsurance are waived for this benefit. This copay applies to the office visit charge only. Other Covered Expenses performed in the office are subject to the deductible and coinsurance.	1-15

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Qualified Practitioner Benefits	Subject to the deductible and coinsurance Anesthesia: PPO deductible/100% to PPO coinsurance limit (for PPO and Non-PPO)	Inpatient and outpatient Hospital visits, surgery and anesthesia.	1-15
Oral Surgery	PPO Deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	Refer to list of covered oral surgeries in text. The Office Visit copay does not apply to this benefit.	1-16
Wellness Benefit	GENERAL PLAN PPO: 100%; deductible waived Non-PPO: Subject to the deductible and coinsurance HRA PLAN (\$1200 Plan): 100%, deductible and coinsurance waived (for PPO and Non-PPO) Immunizations: 100%, deductible and coinsurance waived (for PPO and Non-PPO)	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine prostate exams and routine immunizations. <u>Refer to the text for details and limits.</u> X-rays and Lab Tests: All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit. Mammograms, Pap Smears & Endoscopic Surgeries (e.g. colonoscopies): Payable as shown under the Other Covered Expenses. Immunizations (Under Age 6 Years): Payable as shown under the Childhood Immunization Benefit. The Office Visit copay does not apply to this benefit.	1-17
Outpatient Hospital Benefit	Subject to the deductible and coinsurance		1-17

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p>GENERAL PLAN Plan 1 - Others: \$100 copay per visit/100% (for PPO and Non-PPO)</p> <p>Plan 2 – Highway: \$50 copay per visit/100% (for PPO and Non-PPO)</p> <p>HRA PLAN (\$1200 Plan): \$50 copay per visit, then 100% (for PPO and Non-PPO)</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.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-17
Urgent Care Center Benefits	Subject to the deductible and coinsurance	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all Covered Expenses performed during the visit.	1-18
Ambulatory Surgical Center	Subject to the deductible and coinsurance		1-18
X-ray and Laboratory Tests	Subject to the deductible and coinsurance	<p>Dental x-rays limited to covered oral surgery or Injury.</p> <p>All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-18
Diagnostic Tests Provided and Billed By an Independent Laboratory	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)		1-18
Ambulance Service Benefit	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.	1-18

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pregnancy Benefit	Subject to the deductible and coinsurance	Covered for Employee, spouse and Dependent daughter. The Office Visit copay does not apply to this benefit.	1-18
Newborn Benefits	Subject to the deductible and coinsurance	See "Section 3 – Eligibility" for important information on Dependent Coverage.	1-19
Birthing Center Benefit	Subject to the deductible and coinsurance		1-19
Home Health Care Benefit	100%, deductible and coinsurance waived (for PPO and Non-PPO)	40 visits per Calendar Year, when Home Health Care is in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home. If Your Qualified Practitioner indicates that You are terminally ill, another 40 Home Health Care visits are available each Calendar Year.	1-20
Convalescent Nursing Home Benefit	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non-PPO)	Limited to 30 days per Confinement.	1-21
Hospice Care Benefit	Subject to the deductible and coinsurance	Hospice Care must be in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home.	1-21
Human Organ and Tissue Transplants	PPO: Deductible/ 100% to PPO coinsurance limit Non-PPO: Not Covered (except for kidney transplants) <u>Kidney Transplant</u> Subject to the deductible and coinsurance	Procurement: Limited to \$10,000 paid per organ. (Refer to text for more details.) Refer to the list of covered transplants in the text. Pre-authorization of benefits is required for any transplant procedure. A request for pre-authorization may be submitted in writing to the Claims Administrator.	1-22

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other Sickness or Injury		1-23
Other Covered Expenses	Subject to the deductible and coinsurance		1-25
Chiropractic Care	\$20 copay per visit/100% (for PPO and Non-PPO)	<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 applies to the office visit charge only. Other Covered Expenses performed in the office are subject to the deductible and coinsurance.</p> <p>Routine and maintenance care is not covered.</p>	1-25
Dental Treatment	PPO deductible/ 100% to PPO coinsurance limit (for PPO and Non- PPO)	<p>Refer to the list of Covered Expenses in the text.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-25
Physical, Speech, Occupational and Respiratory Therapy	Subject to the deductible and coinsurance	The Office Visit copay does not apply to this benefit.	1-25
Outpatient Cardiac Rehabilitation	Subject to the deductible and coinsurance	<p>Limited to Phase II only.</p> <p>Limited to three one-hour sessions per week, up to 12 weeks per covered Sickness.</p> <p>Refer to the text for details.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-26

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
TMJ Benefit	Subject to the deductible and coinsurance	<p>Benefits include diagnostic, surgical and non-surgical treatment.</p> <p>Diagnostic and Non-Surgical Treatment: Limited to a combined maximum of \$1,250 paid per Calendar Year.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-26
Routine Childhood Immunizations (State Mandate)	100%, deductible and coinsurance waived (for PPO and Non-PPO)	<p>Limited to Dependent children under the age of six years.</p> <p>Refer to the list of immunizations in the text.</p> <p>This benefit is in addition to any Wellness or Well Child Care benefit that may be part of this Plan.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-27
Mammograms	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine and those related to a Sickness.</p> <p>For any covered female person.</p>	1-27
Pap Smears	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine and those related to a Sickness.</p> <p>For any covered female person.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-27

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Endoscopic Surgeries (e.g. Colonoscopies)	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: Subject to the deductible and coinsurance</p>	<p>Includes routine, those related to a Sickness and those requested due to family history.</p> <p>For any Covered Person.</p>	1-27
Allergy Injections	Subject to the deductible and coinsurance	The Office Visit copay does not apply to this benefit.	1-27
Limitations and Exclusions	Not Payable	List of exclusions that apply to all Covered Expenses. A service that is normally covered may be excluded when provided with an excluded item.	1-31

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay Copays apply per drug/refill.	<p><u>General Plan (Plan 1 – Others)</u> Retail (34-day supply) Generic: \$5 copay Brand: \$10 copay</p> <p>Mail Order (90-day supply) Generic: \$10 copay Brand: \$20 copay</p> <p><u>Out-of-Pocket Limit</u></p> <ul style="list-style-type: none"> ▪ Individual: \$250 per Calendar Year ▪ Family: \$500 per Calendar Year <p>Birth control is covered.</p> <p><u>General Plan (Plan 2 - Highway)</u> Retail (34-day supply) Tier 1 (Generic): \$5 copay Tier 2 (Formulary): \$15 copay Tier 3 (Non-Formulary): \$25 copay</p> <p>Mail Order (90-day supply) Tier 1 (Generic): \$10 copay Tier 2 (Formulary): \$30 copay Tier 3 (Non-Formulary): \$50 copay</p> <p><u>Out-of-Pocket Limit:</u> \$250 per Covered Person, per Calendar Year. (This limit applies to Generic drugs only. It does not apply to Formulary or Non-Formulary drugs.)</p> <p>Birth control is covered.</p> <p><u>HRA Plan (\$1200 Plan)</u> Retail (34-day supply) Generic: \$10 copay Brand: \$20 copay</p> <p>Mail Order (90-day supply) Generic: \$20 copay Brand: \$40 copay</p> <p><u>Out-of-Pocket Limit:</u> \$250 per Covered Person, per Calendar Year. (This limit applies to Generic drugs only. It does not apply to Brand Name drugs.)</p> <p>Birth control is covered.</p>	1-35

AMENDMENT #3

WCA Group Health Trust – Sawyer County
Group Number: WCA0058

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2011.

On page 1-3, the “Plan Lifetime Maximum” section of the Schedule of Benefits is deleted in its entirety.

On page 1-7, the Wellness Benefit section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit	<p>GENERAL PLAN PPO: 100%, deductible waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p>HRA PLAN (\$1200 Plan): 100%, deductible and coinsurance waived (for PPO and Non-PPO)</p> <p>Immunizations: 100%, deductible and coinsurance waived (for PPO and Non-PPO)</p>	<p>Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine prostate exams and routine immunizations.</p> <p><u>Refer to the text for details and limits.</u></p> <p>X-rays and Lab Tests: All covered x-rays and 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>Mammograms, Pap Smears & Endoscopic Surgeries (e.g. colonoscopies): Payable as shown under the Other Covered Expenses.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-17

On page 1-7, the Emergency Room benefit section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p>GENERAL PLAN <u>Plan 1 - Others:</u> \$100 copay per visit/100% (for PPO and Non-PPO)</p> <p><u>Plan 2 – Highway:</u> \$50 copay per visit/100% (for PPO and Non-PPO)</p> <p>HRA PLAN (\$1200 Plan): \$50 copay per visit, then 100% (for PPO and Non-PPO)</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.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-17

On page 1-11, the “Routine Childhood Immunizations” benefit is deleted from the Schedule of Benefits. (Immunizations are payable under the Wellness Benefit, as shown on the Schedule of Benefits.)

On page 1-11, the “Mammograms” section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Mammogram Benefit	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: <u>Routine</u> PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u>Non-Routine:</u> Subject to the deductible and coinsurance</p>	<p>Includes routine mammograms and those related to a Sickness or Injury.</p> <p>For any covered female person.</p>	1-27

On page 1-11, the “Pap Smears” section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pap Smears	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: <u>Routine</u> PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u>Non-Routine:</u> Subject to the deductible and coinsurance</p>	<p>Includes routine pap smears and those related to a Sickness or Injury.</p> <p>For any covered female person.</p>	1-27

On page 1-11, the “Endoscopic Surgeries (colonoscopies)” section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Endoscopic Surgeries (e.g. Colonoscopies)	<p>1st Each Calendar Year: 100%, deductible and coinsurance waived (for all providers)</p> <p>Additional in the Same Calendar Year: <u>Routine</u> PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u>Non-Routine:</u> Subject to the deductible and coinsurance</p>	<p>Includes routine, those related to a Sickness or Injury and those requested due to family history.</p> <p>For any Covered Person.</p>	1-27

On page 1-17, the Wellness Benefit is deleted and replaced with the following:

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. *Covered expenses* include but are not limited to the following:

All Covered Persons

1. Preventive medicine visits (wellness exams);
2. All standard immunizations recommended by the American Committee on Immunization Practices.
3. Third party exams. Including, but not limited to, exams for employment, insurance, school, sports and camps.

Screening/Services For All Covered Persons at Appropriate Ages

1. Elevated cholesterol and lipids;
2. Certain sexually transmitted diseases and HIV (includes counseling);
3. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
4. High blood pressure;
5. Diabetes;
6. Depression;
7. Screening/counseling for obesity (adults and children).

For Women

1. Counseling for genetic testing for BRCA breast cancer gene;
2. Screening for gonorrhea, chlamydia, syphilis;
3. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
4. Instructions to promote and help with breast feeding;
5. Screening for osteoporosis;
6. Counseling for those at high risk for breast cancer for chemoprevention.

For Men

1. Screening for prostate cancer;
2. Screening for abdominal aortic aneurysm.

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis;
6. Fluoride for prevention of dental cavities.

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.

In addition to the general Limitations and Exclusions of the Plan, no benefits are payable under this Wellness Benefit for:

1. Medical examinations for Injury or Sickness;
2. Medical examinations caused by or related to a pregnancy;
3. Eye examinations for the purpose of prescribing corrective lenses;
4. Hearing tests;
5. Any dental examinations;
6. Mammograms. (These are payable under a separate benefit, as shown on the Schedule of Benefits.)

7. Pap smears. (These are payable under a separate benefit, as shown on the Schedule of Benefits.) or
8. Endoscopic surgeries (e.g. colonoscopies). (These are payable under a separate benefit, as shown on the Schedule of Benefits.)

On page 1-26, Item #14 (blood lead tests) is removed from the list of Other Covered Expenses. (These tests are covered under the updated Wellness Benefit.)

On page 1-27, Item #18 (routine childhood immunizations) is removed from the list of Other Covered Expenses. (Immunizations are payable under the Wellness Benefit, as shown on the Schedule of Benefits.)

On page 1-32, Exclusion #3 under the “Physical Appearance” exclusions is amended to read as follows:

3. Any treatment or services for **weight control or reduction**. 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; except as specifically stated for preventive counseling; or any obesity surgery, including, but not limited to stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy. Note: This exclusion does not include gastrointestinal surgery for morbid obesity. Morbid obesity is defined as having a Body Mass Index of 40 or greater.

On page 1-32, the following “Note” is added to the Pre-Existing Condition exclusion:

Note: The Pre-Existing Conditions exclusions do not apply to any Covered Person under age 19.

On page 1-33, Exclusion #4 under the “Reproduction” exclusions is amended to read as follows:

4. **Genetic testing or counseling**, unless required to treat the Sickness or Injury of a Covered Person or used in the treatment of a high risk pregnancy, unless specifically stated otherwise as a Covered Expense; or

On pages 2-4 and 2-5, Item #2 under the definition of “Dependent” is deleted and replaced with the following:

2. A covered Employee’s married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee’s legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age. The limiting age for each dependent child is shown below:

A married or unmarried Dependent child may be covered under the Plan until the end of the Calendar Year in which such child reaches age 26.

After age 26, an unmarried Dependent child may be covered until the end of the month in which such child reaches age 27, provided such child is not eligible for coverage under a group health benefit plan offered by his or her employer (and for which the premium contribution amount is no greater than that for coverage as a Dependent under the this Plan).

Coverage may be extended (beyond age 27) for a Dependent child if **all** of the following requirements are met:

- a. The Dependent child is a full-time student, regardless of age, and
- b. The Dependent child is not married and is not eligible for coverage under a group health benefit plan offered by their own employer (and for which any required plan contribution amount is no greater than that for coverage as a Dependent under the Employee), and
- c. The Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- d. The Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child’s attending Qualified Practitioner:

- a. the date the child’s coverage would terminate for reasons other than not being a full-time student,
- b. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

On page 2-5, the following is added at the end of the definition of “Dependent”:

Right To Check Dependent Eligibility

The Plan reserves the right to check the eligibility status of a Dependent at any time during the year. You and Your Dependent have an obligation to notify the Plan when the Dependent’s eligibility status changes during the year. Please notify Your Employer of any status changes.

On page 2-5, the definition of “Emergency” is amended to read as follows:

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. A condition is considered to be an Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient’s life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

On page 2-10, the following “Note” is added to the definition of “Pre-Existing Condition”:

Note: The Pre-Existing Condition exclusions do not apply to any Covered Person under age 19.

On page 2-10, the Pre-Existing Conditions Exceptions section is amended to read as follows:

Pre-Existing Condition Exceptions

The exclusion will not apply:

- a. to any Covered Expense due to pregnancy, or
- b. to any condition that has not been diagnosed by a Qualified Practitioner, but has been indicated by genetic testing.

The following definitions are added to the “Definitions” section of the Plan:

Essential Health Benefits

Any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, etc.

Non-Essential Health Benefits

Any medical expense that is not an Essential Benefit. Please refer to the Essential Health Benefits definition.

Prudent Layperson

A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

On page 3-2, the last paragraph under the “Dependent Effective Date of Coverage” section is deleted in its entirety.

On page 3-3, the “Loss of Other Coverage” list under the Special Enrollment Rights is amended to read as follows:

Loss of Other Coverage

If You declined coverage under this Plan in favor of other group or individual health coverage, or COBRA continuation, and coverage under that 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 Employer contributions towards the cost of the other coverage;
4. The amount of premiums Your spouse is required to pay, for covered under the spouse’s plan, goes up by at least 25% of the family plan rate; or
5. The amount of contribution You are required to pay for coverage under this Plan goes down by at least 25% of the family plan rate.

On page 3-6, the following is added after the “Termination of Coverage” section:

Rescission of Coverage

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

On page 4-2, the following is added to the “Coordination of Benefits” section of the plan (before the Coordination of Benefits between Medical and Dental Plans section):

When an individual is covered under a spouse’s plan and also under his or her parent’s plan, the primary plan is the plan of the individual’s spouse. The plan of the individual’s parent(s) is the secondary plan.

On pages 4-6 and 4-7, the “Claim Review Procedure” section is amended to read as follows:

CLAIM REVIEW PROCEDURE

The rules stated in this section shall be followed by all persons and entities seeking review of any decision as to eligibility for benefits, the amount of benefits paid or a rescission of coverage determination. These rules shall be the exclusive remedy for any such decision, except as otherwise required by applicable law.

Request for Review

Any participating Employee or beneficiary who has been affected by a decision to deny a claim for benefits, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after the mailing of a written notice of the denial of the claim or of the amount of the benefits to be paid. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

Review

On timely receipt of a request for review, the Claims Review Committee shall schedule a review within **sixty (60) days** of receipt of the request. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Decision

The Claims Review Committee shall issue a written decision within **ten (10) days** after the end of the review, affirming, modifying or setting aside the previous decision or action. The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

To submit a request of claim review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee
WCA Group Health Trust
22 East Mifflin Street, Suite 900
Madison, WI 53703

On page 4-7, the following is added to the end of the Claim Appeal Procedure section:

Federal External Review Program

The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments, You will be provided with additional information concerning the process.

Contact UMR at the telephone number shown on Your ID card for more information on the Federal external review program.

AMENDMENT #4

WCA Group Health Trust – Sawyer County
Group Number: WCA0058

BENEFITS PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2011.

The following definitions are added to the “Definitions” section of the Plan:

Post-Service Claim

Any claim that is not a Pre-Service Claim.

Pre-Service Claim

Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the Plan for the medical care.

Urgent Care

Any care that in the opinion of Your Qualified Practitioner is an urgent care situation. Any care that the use of non-urgent care time frames would put Your life, health or ability to regain maximum function at risk.

In the “General Provisions” section of the Plan, the “Time of Claim Determination” section is deleted and replaced with the following:

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, Your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the Plan will notify You of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the Plan will give its decision on the claim. If You fail to provide the information requested by the Plan, the Plan will provide You with its decision on the claim within 48 hours of the end of the period that You were given to provide the information.

If You fail to follow the Plan procedure for a Pre-Service Claim, the Plan will notify You within 24 hours of the Plan’s receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

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

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, Your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-Urgent Care claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If You fail to follow the Plan procedure for a non-Urgent Care Pre-Service Claim, the Plan will notify You within five days of the Plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The Plan may extend this period by 15 days if; You are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the Plan's control. If an extension is due to the need for additional information, the Plan will notify You of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

The "Claim Review Procedure" provision in the General Provisions section of the Plan deleted and replaced with the following:

CLAIM APPEAL PROCEDURE

A two-level appeal process is available under this Plan, followed by the Federal External Review Program. The first level of appeal is to the Claims Administrator (UMR). If You disagree with the result of the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust).

FIRST LEVEL OF APPEAL

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

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

2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of Your appeal.

A request for a review must be filed with the Claims Administrator within 180 days after receipt of the claim denial. If Your request for review is not received within 180 days, Your right to appeal the claim denial is forfeited.

If Your request for review is received within 180 days, a full and fair review of the claim will be held by the Claims Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide that information to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

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

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

SECOND LEVEL OF APPEAL

If You disagree with the Plan's decision on the first level of appeal, You may appeal to the Plan Administrator (the WCA Group Health Trust) by using the procedures outlined below:

Request for Review

Upon completion of the first level of appeal, any participating Employee or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Claims Review Committee to review the claim. The written request must be submitted to the Claims Review Committee within **ninety (90) days** after receipt of the Plan's decision on the first level of appeal. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating Employee or beneficiary wishes to present.

To submit a request for review to the Claims Review Committee, please mail the written request to the principal office of the Trust at:

Claims Review Committee
WCA Group Health Trust
22 East Mifflin Street, Suite 900
Madison, WI 53703

Review

Upon timely receipt of a request for review, the Claims Review Committee will schedule a review of your appeal. The Claims Review Committee ordinarily meets by telephone conference. You will be notified of the date and time of the telephone conference and of how You may participate in the telephone conference, if You wish. At the telephone conference, You may add any information You wish. However, You may not remain on the telephone conference when the Claims Review Committee deliberates and decides Your claims. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Claims Review Committee will provide that information to You free of charge and sufficiently in advance of the due date of the response to the Your appeal.

Decision

You will be notified of the Claims Review Committee's decision as follows, affirming, modifying or setting aside the previous decision or action:

1. For Urgent Care claims, within 72 hours or as soon as possible if Your condition requires a shorter time frame;
2. For Pre-Service Claims, within 15 days or as soon as possible if Your condition requires a shorter time frame; or
3. For Post-Service Claims, within 30 days.

An expedited appeal process is available for Urgent Care cases.

The written decision of the Claims Review Committee shall be based on the record at the review and shall be final, except as otherwise required by law.

FEDERAL EXTERNAL REVIEW PROGRAM

The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments, You will be provided with additional information concerning the process.

Contact UMR, Inc. at the telephone number shown on Your ID card for more information on the Federal external review program.

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE MAY 1, 2011.

THE CHANGES IN THIS AMENDMENT APPLY TO THE HRA PLAN ONLY.

On page 1-5, the “Coinsurance” section of the Schedule of Benefits for the \$1200 Plan (the HRA Plan) is amended to read as follows. (The deductible and out-of-pocket limits are not changing.)

MEDICAL BENEFITS (\$1,200 Plan/HRA)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Individual Coinsurance per Calendar Year			After the deductible, the coinsurance amounts shown apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	1-13
PPO	100%	0%		
Non-PPO	70%	30%		

On page 1-7, the Emergency Room benefit section of the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p>GENERAL PLAN Plan 1 - Others: \$100 copay per visit/100% (for PPO and Non-PPO)</p> <p><u>Plan 2 – Highway:</u> \$50 copay per visit/100% (for PPO and Non-PPO)</p> <p>HRA PLAN (\$1200 Plan): \$100 copay per visit, then 100% (for PPO and Non-PPO)</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.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-17

AMENDMENT #6

**WCA Group Health Trust – Sawyer County
Group Number: WCA0058**

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2012.

Effective January 1, 2012, the “Highway Plan” is deleted in its entirety.

Effective January 1, 2012, this Plan will have the following Plan Options:

- The HRA Plan
- The General Plan (Plan 1)

AMENDMENT #7

WCA Group Health Trust – Sawyer County
Group Number: WCA0058

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2012.

On page 2-4, Item #2 under the definition of “Dependent” is deleted and replaced with the following:

2. A Covered Employee’s married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the Employee’s legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

The limiting age for each Dependent child is the last day of the Calendar Year in which such child reaches age 26.

Coverage may be extended (beyond age 26) for a Dependent child if **all** of the following requirements are met:

- a. The Dependent child is a full-time student, regardless of age, and
- b. The Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- c. The Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child’s attending Qualified Practitioner:

1. the date the child’s coverage would terminate for reasons other than not being a full-time student,
2. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

All references in the Plan to “Notice Requirements” or “Pre-Certification” are deleted and replaced with “Prior Authorization” in the context of pre-notification/pre-certification to the Plan.

Any references in the Plan to “Clinical Eligibility for Coverage” are deleted and replaced with Medically Necessity or Medically Necessary.

On page 1-34, Exclusion #2 under the “Other” exclusions is deleted and replaced with the following:

2. Services **not Medically Necessary** for diagnosis and treatment of an Injury or Sickness;

On page 2-2, the definition of “Clinical Eligibility for Coverage”, is deleted in its entirety.

The following definition is added to the “Definitions” section of the Plan:

Medically Necessary

Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the Plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Sickness, Injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and
3. Not mainly for Your convenience or that of Your Qualified Practitioner; and
4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Sickness. Injury or symptoms.

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

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Utilization Management (UM) develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UM and revised from time to time), are available to You by calling UMR, Inc. at the telephone number shown on Your ID card, and to Qualified Practitioners, physicians and other health care professionals on UnitedHealthcareOnline.com.

The following definition is added to the “Definitions” section of the Plan:

Prior Authorization

The process of determining benefit coverage prior to service being rendered to a Covered Person. A determination is made based on medical necessity (Medically Necessary) criteria for services, tests or procedures that are appropriate and cost-effective for the Covered Person. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

On page 4-7, the “Federal External Review Program” section that was added to the Plan with Amendment #3 (under Claim Appeals) is deleted and replaced with the following:

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;
2. The exclusion for experimental or investigational services or unproven services; or
3. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR, Inc. or Your Employer fail to respond to Your appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither You nor UMR, Inc. or Your Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision. If You wish to pursue an external review, please send a written request to the following address:

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include:

1. Your specific request for an external review;
2. The Employee’s name, address, and member ID number;
3. Your designated representative's name and address, when applicable;
4. The service that was denied; and
5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a Covered Expense by the Plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or Your Employer. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or Your Employer in making a decision on the case; and
3. All other information or evidence that You or Your physician has already submitted to UMR, Inc. or Your Employer.

If there is any information or evidence You or Your physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR, Inc. and/or Your Employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2012.

On page 1-12, the following benefit is added to the Schedule of Benefits:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Health Club Benefit	100%, deductible and coinsurance waived	For Covered Employees and Covered Dependent Spouses only. Limited to \$100 paid per Covered Employee per Calendar Year and \$100 paid per Covered Dependent Spouse per Calendar Year.	1-30

On page 1-12, the following benefit is added to the Schedule of Benefits:

COVERED EXPENSES (All Plans)	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Routine Vision Exams	100%, deductible and coinsurance waived	Limited to once per Calendar Year. Includes refractions.	1-30

On page 1-17, Item #3 under the Wellness Benefit “exclusions” is amended to read as follows:

- Eye examinations for the purpose of prescribing corrective lenses. (Routine vision exams are payable under a separate benefit, as shown on the Schedule of Benefits.)

On page 1-30, the following benefit is added to the list of Other Covered Expenses:

- Health Club Benefit. For Covered Employees and Covered Dependent spouses only. Subject to the limits shown on the Schedule of Benefits.

On page 1-30, the following benefit is added to the list of Other Covered Expenses:

~~29. Routine vision exams for any Covered Person. Includes refractions. Limited to once per Calendar Year.~~

On page 1-33, Exclusion #1 under the “Routine and General Health” exclusions is amended to read as follows:

1. **Vision therapy** (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, hearing aids (except as specifically stated for hearing aids or cochlear implants) or the examination, fitting or repair of any hearing aid or eyeglasses. The initial purchase of eyeglasses or contact lenses for aphakia, keratoconus and after a cataract surgery is a Covered Expense., (Note: Certain hearing aids, cochlear implants and related treatment are payable as specifically described under the Other Covered Expenses. Routine vision exams are payable as shown on the Schedule of Benefits.)

AMENDMENT #9

WCA Group Health Trust – Sawyer County
Group Number: WCA0058

BENEFITS PLAN AMENDMENT

IT IS UNDERSTOOD AND AGREED THAT:

In the COBRA section of the Plan, the third paragraph under the section entitled “Additional Election Period Due to The Trade Act of 2002” is amended to read as follows:

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.

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 72.5% 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

AMENDMENT #12

WCA Group Health Trust – Sawyer County
Group Number: WCA0058

BENEFITS PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

THE CHANGES IN THIS AMENDMENT ARE EFFECTIVE JANUARY 1, 2014:

All references throughout the Plan to the General Plan (\$200 Plan) are deleted in their entirety. As of 1/1/14, this plan option is no longer offered.

All references throughout the plan to the Pre-Existing Condition Exclusions are deleted in their entirety.

All references to Convalescent Nursing Home are deleted in their entirety and replaced with Extended Care Facility.

All references to Chiropractic Care are deleted in their entirety and replaced with Manipulations.

On page 1-5, the Medical Benefits portion of the Schedule of Benefits is amended to read as follows:

Plan Lifetime Maximum: Unlimited

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee + 1 Family	 \$0 \$0 \$0 \$0 \$0 \$0	 \$1,500 \$3,000 \$4,000 \$1,500 \$3,000 \$4,000	The amount You must pay each year before the Plan will begin paying any benefits. PPO and Non-PPO Employee +1 and Family maximums are on an aggregate dollar basis.	
Individual Coinsurance per Calendar Year PPO Non-PPO	 100% 70%	 0% 30%	After the deductible, the coinsurance amounts shown apply. After which the Plan pays 100% of Covered Expenses subject to any maximums.	
Out-of-Pocket Limit per Calendar Year PPO Individual Employee +1 Family Non-PPO Individual Employee +1 Family		 \$1,500 \$3,000 \$4,000 \$2,000 \$4,000 \$5,000	Represents the total paid by You for the deductible, coinsurance, copays (if applicable) and embedded vision. After which the Plan pays 100% of Covered Expenses subject to any maximums. PPO and Non-PPO Employee + 1 and Family maximums are on an aggregate dollar basis. Your out-of-pocket expense for a Calendar Year will never exceed the Non-PPO out-of-pocket limit. <i>PPO and Non-PPO:</i> All copays are included in the out-of-pocket limit except Prescription Drug Card copays.	
All Covered Expenses under the Plan are payable at the Plan's Usual, Customary and Reasonable limits. The deductible and coinsurance limits shown above apply to all Covered Expenses unless stated otherwise below.				

On page 1-6, the “Qualified Practitioner Office Services Benefit” in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Qualified Practitioner Office Services Benefit	\$20 copay per visit, then subject to the deductible and coinsurance (for PPO and Non-PPO)	This copay applies to the office visit charge only.	

On page 1-7, the “Emergency Room Benefit” in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	\$100 copay per visit, then PPO deductible/100% to PPO coinsurance limit for all providers	<p>This copay is waived if You are admitted to the Hospital from the Emergency Room.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	

On page 1-9, the “Convalescent Nursing Home Benefit” in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Extended Care Facility	Subject to the deductible and coinsurance	Limited to 30 days per Confinement.	

On page 1-9, the “Human Organ and Tissue Transplant” benefit in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Human Organ and Tissue Transplants	<p>PPO: Deductible/100% to PPO coinsurance limit</p> <p>Non-PPO: Not Covered (except for kidney transplants)</p> <p><u>Kidney Transplant</u> Subject to the deductible and coinsurance</p>	<p>Procurement: Limited to \$10,000 paid per transplant. (Refer to text for more details).</p> <p>Refer to the list of covered transplants in the text.</p> <p>Pre-authorization of benefits is required for any transplant procedure. A request for pre-authorization may be submitted in writing to the Claims Administrator.</p>	

On page 1-10, the “Chiropractic Care” benefit in the Schedule of Benefits is deleted in its entirety and replaced with the following:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Manipulations	\$20 copay per visit/100% (for PPO and Non-PPO)	<p>The deductible and coinsurance are waived for this benefit.</p> <p>Routine and maintenance care is not covered.</p> <p>This benefit applies to manipulations billed by any Qualified Practitioner. Any other service received in association with the manipulation will be payable as any other Sickness or Injury.</p>	

On page 1-10, the "TMJ Benefit" in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
TMJ Benefit	Subject to the deductible and coinsurance	Benefits include diagnostic, surgical and non-surgical treatment. The Office Visit copay does not apply to this benefit.	

On page 1-12, the "Prescription Drug Card" section in the Schedule of Benefits is amended to read as follows:

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay Copays apply per drug/refill.	Birth control is covered. Retail (34-Day Supply) Tier 1 (Generic): \$10 copay Tier 2 (Formulary): \$20 copay Tier 3 (Brand): \$40 copay Retail (35 to 90-Day Supply) Tier 1 (Generic): \$20 copay Tier 2 (Formulary): \$40 copay Tier 3 (Brand): \$80 copay Mail Order (90-day supply) Tier 1 (Generic): \$20 copay Tier 2 (Formulary): \$40 copay Tier 3 (Brand): \$80 copay Note: Prescription Drug copays do not apply to the medical out-of-pocket limits.	

On page 1-13, the 4th Quarter Deductible Carryover Credit section is deleted in its entirety.

On page 1-13, the Out-of-Pocket Limit section is amended to read as follows:

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, coinsurance, copays (if applicable) and embedded vision. 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 penalties for failure to comply with the Prior Authorization Requirements of the Plan.

On page 1-14, the Case Management section is amended to read as follows:

CASE MANAGEMENT

Case management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

On page 1-21, Convalescent Nursing Home is deleted in its entirety and replaced with the following:

EXTENDED CARE FACILITY

Charges for room and board and nursing care are 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.

On page 1-20 and 1-21, the Home Health Care section is amended to read as follows:

HOME HEALTH CARE BENEFIT

Home Health Care services are provided for patients when determined Medically Necessary.

Covered Expenses may include:

1. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge for the same service in a provider's office.
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
3. Nutrition counseling provided by or under the supervision of a qualified dietician, or other Qualified Practitioner, if applicable.
4. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a qualified therapist, or other qualified practitioner, if applicable.
5. Medical supplies, drugs, or medication prescribed by a physician and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a qualified therapist, qualified dietician, or other Qualified Practitioner, if applicable.

EXCLUSIONS

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

1. Homemaker or housekeeping services.
2. Supportive environment materials such as handrails, ramps, air conditioners and telephones.
3. Services performed by family members or volunteer workers.
4. "Meals on Wheels" or similar food service.
5. Separate charges for records, reports or transportation.
6. Expenses for the normal necessities of living such as food, clothing and household supplies.
7. Legal and financial counseling services, unless otherwise covered under this Plan.

On page 1-26, item 13 of the "Other Covered Expenses" section is amended to read as follows:

13. Temporomandibular Joint (TMJ) surgical, non-surgical and diagnostic treatment. Benefits include prescribed intraoral splint therapy devices. Benefits include appliances and therapy for any jaw joint problem, including any temporomandibular joint disorder, craniomaxillary or craniomandibular disorder or other conditions of the jaw joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof, including headaches. These Covered Expenses do not include cosmetic or elective orthodontic care, periodontal care or general dental care.

On page 1-27, item 23 is deleted in its entirety and replaced with the following:

23. Qualifying clinical trials as defined below, including routine patient care costs as defined below incurred during participation in a qualifying clinical trial for the treatment of:

Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials may include:

1. Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
2. Covered health services required solely for the administration of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

1. The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
4. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that meets any of the following criteria in the bulleted list below.

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- *National Institutes of Health (NIH)*, including the *National Cancer Institute (NCI)*;
 - *Centers for Disease Control and Prevention (CDC)*;
 - *Agency for Healthcare Research and Quality (AHRQ)*;
 - *Centers for Medicare and Medicaid Services (CMS)*;
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veteran's Administration (VA)*;
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - The *Department of Veterans Affairs*, the *Department of Defense*, or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
 3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
 4. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The plan sponsor may, at any time, request documentation about the trial; or
 5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

On page 1-34, item 15 in the list of "Other" exclusions is amended to read as follows:

15. Any service or supply 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 (e.g. the Qualifying Clinical Trial benefit).

On page 2-3, the Definition of Convalescent Nursing Home is deleted in its entirety.

The following definitions are added to the plan as follows:

Extended Care Facility

A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. 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. With 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 during convalescence from Sickness or Injury.

An Extended Care Facility is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Pediatric Services

Services provided to a Covered Person under the age of 19.

On page 2-6, the definition of Home Health Care is amended to read as follows:

Home Health Care

A formal program of care and intermittent treatment that is: Performed in the home; prescribed by a physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or qualified licensed providers under the medical direction of a physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

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

On page 2-7, the definition of Home Health Care Plan is amended to read as follows:

Home Health Care Plan

A formal, written plan made by the Covered Person's Qualified Practitioner that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

On page 2-10, the definition of Qualified Practitioner is amended to read as follows:

Qualified Practitioner

A provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan. A Qualified Practitioner's services are not covered if the practitioner resides in Your home or is a Family Member.

The following is added to the Plan prior to the Prior Authorization section:

TRANSITION OF CARE/CONTINUITY OF CARE

Note: This provision is limited to Employees and their eligible Dependents who were covered under this Plan prior to January 1, 2014.

The Transition of Care provision applies to a Covered Person who is receiving specific treatment from a Non-PPO provider on the effective date of this amendment January 1, 2014. This provision allows a transition period before You are required to transfer from a Non-PPO provider to a PPO provider in order to receive PPO benefits for Covered Expenses under this Plan. Under this provision, Covered Expenses from a Non-PPO provider are payable under the PPO benefits for a limited period of time, subject to the conditions listed below. This transition period applies only to current treatment for the specific health conditions listed below.

The Transition of Care policy applies to the following clinical conditions only, subject to the stated limitations:

1. End-stage renal disease and dialysis: Limited to 90 days. Applies to Qualified Practitioner and dialysis services.
2. Cancer treatment: Limited to completion of the current course of treatment, not to exceed 12 consecutive months from the effective date of this amendment January 1, 2014. Treatment includes, but is not limited to, surgery, chemotherapy, radiation and follow-up visits.
3. Pregnancy (any stage). Limited to services provided through the post-partum follow-up period.
4. Charges for the newborn child of a Covered Person whose pregnancy was subject to this Transition of Care provision until the child's initial discharge from the Hospital.
5. Surgical procedures that are pending and pre-certified prior to the effective date of this amendment January 1, 2014. Limited to services provided through the post-surgical follow-up period.
6. Symptomatic AIDS: Limited to 90 days.
7. Transplants (Solid organ and bone marrow).
8. Therapy – Physical, Occupational, Speech Therapy. Limited to 90 days or the completion of current treatment plan, whichever is shorter.
9. Conditions where Transition of Care coverage is required by federal or state law.

On page 1-4, the PPO Benefit Provision is amended to read as follows:

Exceptions to the Provider network Rates (PPO Benefit Provision)

Some benefits may be processed at the PPO benefit level when provided by a Non-PPO provider.

The following exceptions may apply:

1. PPO benefits will be payable for Non-PPO provider services **only** if you receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred for pathology, radiology or anesthesiology services from a Non-PPO provider.
2. You are currently under a care plan with a Non-PPO provider and the care is eligible under the Transition of Care/Continuity of Care provision of this Plan.
3. Covered Expenses provided by a Qualified Practitioner during an Inpatient stay will be payable at the PPO level of benefits when provided at a PPO Hospital.
4. Covered Expenses provided by an Emergency room Qualified Practitioner will be payable at the PPO level of benefits when provided at a PPO Hospital.
5. If there is not a PPO provider, or no PPO provider is willing or able to provide the necessary service(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Non-PPO charges will be processed as PPO charges so long as the Covered Person provides appropriate documentation.

IN WITNESS WHEREOF, the undersigned has caused this Amendment to be duly adopted and effective as January 1, 2014.

By: Michelle Jepson
Authorized Representative

By: _____
Authorized Representative
WCA Group Health Trust

Title: Human Resources

Title: _____

Date: 3/24/2014

Date: _____

