

**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 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.

IN WITNESS WHEREOF, the undersigned has caused this Amendment to be duly adopted and effective as of March 31, 2010.

By: Josh Bindl  
Authorized Representative - WCA Group Health Trust

Title: Assistant Secretary, Trust Board

Date: 10/5/10

**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**

<b>MEDICAL BENEFITS (General Plan)</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>	<b>BENEFIT SUMMARY</b>	<b>TEXT PAGE</b>
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
<b>Plan 1 (Others)</b>				
PPO	100%	0%		
Non-PPO	70%	30%		
<b>Plan 2 (Highway)</b>				
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 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><b>PPO Benefit Provision</b> PPO Benefits will be payable for Non-PPO provider services <b>only</b> 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>				

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  <b>Anesthesia:</b> 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	<b>GENERAL PLAN PPO:</b> 100%, deductible waived  <b>Non-PPO:</b> Subject to the deductible and coinsurance  <b>HRA PLAN (\$1200 Plan):</b> 100%, deductible and coinsurance waived (for PPO and Non-PPO)  <b>Immunizations:</b> 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>  <b>X-rays and Lab Tests:</b> 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.  <b>Mammograms, Pap Smears &amp; Endoscopic Surgeries (e.g. colonoscopies):</b> Payable as shown under the Other Covered Expenses.  <b>Immunizations (Under Age 6 Years):</b> 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><b>GENERAL PLAN</b> <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><b>HRA PLAN</b> <b>(\$1200 Plan):</b> \$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)  <b><u>Kidney Transplant</u></b> Subject to the deductible and coinsurance	<b>Procurement:</b> 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><b>Diagnostic and Non-Surgical Treatment:</b> 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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b> 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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b> 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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b> 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><b><u>General Plan (Plan 1 – Others)</u></b>  <b>Retail (34-day supply)</b>  Generic: \$5 copay  Brand: \$10 copay</p> <p><b>Mail Order (90-day supply)</b>  Generic: \$10 copay  Brand: \$20 copay</p> <p><b><u>Out-of-Pocket Limit</u></b></p> <ul style="list-style-type: none"> <li>▪ Individual: \$250 per Calendar Year</li> <li>▪ Family: \$500 per Calendar Year</li> </ul> <p>Birth control is covered.</p> <p><b><u>General Plan (Plan 2 - Highway)</u></b>  <b>Retail (34-day supply)</b>  Tier 1 (Generic): \$5 copay  Tier 2 (Formulary): \$15 copay  Tier 3 (Non-Formulary): \$25 copay</p> <p><b>Mail Order (90-day supply)</b>  Tier 1 (Generic): \$10 copay  Tier 2 (Formulary): \$30 copay  Tier 3 (Non-Formulary): \$50 copay</p> <p><b><u>Out-of-Pocket Limit:</u></b> \$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><b><u>HRA Plan (\$1200 Plan)</u></b>  <b>Retail (34-day supply)</b>  Generic: \$10 copay  Brand: \$20 copay</p> <p><b>Mail Order (90-day supply)</b>  Generic: \$20 copay  Brand: \$40 copay</p> <p><b><u>Out-of-Pocket Limit:</u></b> \$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

WCA Group Health Trust – Sawyer County  
Amendment #2

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of January 1, 2011.

By: Kris Mayberry 1-5-2010  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: County Clerk

Title: \_\_\_\_\_

Date: 12/5/2010

Date: \_\_\_\_\_

**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><b>GENERAL PLAN</b>  <b>PPO:</b> 100%, deductible waived</p> <p><b>Non-PPO:</b> Subject to the deductible and coinsurance</p> <p><b><u>HRA PLAN (\$1200 Plan):</u></b>                      100%, deductible and coinsurance waived (for PPO and Non-PPO)</p> <p><b><u>Immunizations:</u></b>                      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><b>X-rays and Lab Tests:</b> 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><b>Mammograms, Pap Smears &amp; Endoscopic Surgeries (e.g. colonoscopies):</b> 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><b>GENERAL PLAN</b>  <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><b>HRA PLAN (\$1200 Plan):</b> \$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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b>  <u><b>Routine</b></u>            PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u><b>Non-Routine:</b></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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b>  <u><b>Routine</b></u>            PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u><b>Non-Routine:</b></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><b>1<sup>st</sup> Each Calendar Year:</b> 100%, deductible and coinsurance waived (for all providers)</p> <p><b>Additional in the Same Calendar Year:</b>  <u><b>Routine</b></u>            PPO: 100%, deductible and coinsurance waived</p> <p>Non-PPO: Subject to the deductible and coinsurance</p> <p><u><b>Non-Routine:</b></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 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.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2011.

By: Kris Mayberry  
Authorized Representative

Kris Mayberry

Title: Sawyer County Clerk

Date: 2-15-2011

By: \_\_\_\_\_

Authorized Representative  
WCA Group Health Trust

Title: \_\_\_\_\_

Date: \_\_\_\_\_

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.

Claim Appeal Amendment  
January 1, 2011

IN WITNESS WHEREOF, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2011.

By: Josh Bindel  
Authorized Representative  
WCA Group Health Trust

Title: Assistant Secretary, Trust Board

Date: 3/7/11

**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 ( <b>\$1,200 Plan/HRA</b> )	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><b>GENERAL PLAN</b>  <b>Plan 1 - Others:</b>                      \$100 copay per visit/100% (for PPO and Non-PPO)</p> <p><b>Plan 2 – Highway:</b>                      \$50 copay per visit/100% (for PPO and Non-PPO)</p> <p><b>HRA PLAN</b>  <b>(\$1200 Plan):</b> \$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

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of May 1, 2011.

By: Kris Mayberry  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative  
WCA Group Health Trust

Title: County Clerk

Title: \_\_\_\_\_

Date: 4/20/2011

Date: \_\_\_\_\_