WISCONSIN HEALTH FUND

SUMMARY PLAN DESCRIPTION FOR ACTIVE AND RETIRED PARTICIPANTS

IMPORTANT INFORMATION

2020

This Summary Plan Description supersedes and replaces all materials previously issued.

FROM THE BOARD OF TRUSTEES

We are very proud to provide you and your family with, what we believe to be, one of the finest health care plans in the country. Our plans are dedicated to serving your health care needs, and your coverage is a result of the collective bargaining process between your employer and your respective union. Together we have worked to build a program that offers quality coverage at a competitive price. After comparing our coverage with others, we are proud of the plans we offer to our participants and beneficiaries.

Please set aside some time to go through this Booklet along with your family to learn all about the benefits your plan offers, and to ensure that you and your family receive all of the benefits to which you are entitled. Wishing you the very best!

Sincerely,

The BOARD OF TRUSTEES of the WISCONSIN HEALTH FUND

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ABOUT THIS SUMMARY PLAN DESCRIPTION BOOKLET

Your health and welfare benefits are provided through the Wisconsin Health Fund (which is also referred to as the "**Fund**" and "**WHF**" in this booklet) under an employee welfare benefit plan (which is also referred to as the "**Plan**" in this booklet) governed by federal law. This summary plan description booklet (which is also referred to as "**Booklet**" herein) describes and explains the health and welfare benefits that may be available to you as a Participant covered by the Fund, as well as some important restrictions and responsibilities. It provides a general description of the most important provisions of your benefits, and is written in non-technical language.

We have prepared this Booklet to serve as an easy-to-use reference when you have questions about your benefits as provided through the Fund. Recently, changes have been made to your health care benefits. Please take the time to read through this Booklet and familiarize yourself with these changes, and then keep the Booklet handy to serve as a reference guide.

In summarizing the technical language of the Wisconsin Health Fund Plan Document (which is also referred to as the "**Plan Document**" in this Booklet) into the easy-to-use language provided in this Booklet, great care has been taken to make this Booklet as accurate a source of information as possible regarding the benefits available to you, your spouse and your Dependents. However, this Booklet is *not* meant to interpret, extend or change in any way the provisions of the Plan Document. If any information in this Booklet conflicts with the Plan Document, the Plan Document will control.

You are hereby instructed to read this Booklet carefully, and in its entirety, as it describes your coverage rights and obligations.

It is your responsibility to read and understand the terms and conditions contained in this Booklet.

Questions? The Wisconsin Health Fund Plan Document itself is located at the Wisconsin Health Fund office, and a copy of this document is available to you upon request. If after reading through this Booklet you have any questions about your benefits which have not been fully answered, please feel free to consult the Plan Document or call the Wisconsin Health Fund Customer Service Department at 1-888-208-8808, or send your question in writing to:

Wisconsin Health Fund
6200 West Bluemound Road
Milwaukee, WI 53213

ABOUT YOUR HEALTH PLAN

In 1952, two labor advisory councils and the Teamsters "General" Local Union No. 200, entered into an Agreement and Declaration of Trust (which is also referred to as "**Trust Agreement**" herein) establishing what was known as the Milwaukee Area Truck Drivers Health and Welfare Fund (which is also referred to as "**Milwaukee Area Fund**" herein). Over the years the Trust Agreement was amended and restated, as necessary and appropriate, and other local unions also became participants in the Milwaukee Area Fund. The Milwaukee Area Fund later merged with the Wisconsin Area Health Fund, and the combined funds became known as the Wisconsin Health Fund on January 1, 1994.

Your health plan's name is the Wisconsin Health Fund group health plan. The Wisconsin Health Fund's Employer Identification Number is 39-6063342, and the Plan Number is 501. The type of plan is: Medical; Life Insurance; Accidental Death and Dismemberment; Total Disability Income (Loss of Time); Vision; Pharmacy; and Dental. The Plan year ends every December 31st.

The terms of this Booklet and the Plan Document are legally enforceable, and the Plan is maintained for the exclusive benefit of Participants, beneficiaries, Retirees and Covered Persons. The Fund makes medical, dental, vision, prescription drug, chiropractic and retiree benefits available to certain Participants, beneficiaries, Retirees and Covered Persons, subject to the terms of this Booklet and the Plan Document. The Plan also provides total disability income (loss of time), life, accidental death and dismemberment and other benefits to certain Participants who are actively employed at work and other Covered Persons. Only Participants, beneficiaries, Retirees and Covered Persons are entitled to receive benefits under the Plan. You cannot assign or transfer your rights under the Plan.

Life Insurance and Accidental Death and Dismemberment benefits payable under the Plan are provided through a policy of group insurance issued by a licensed life insurance carrier selected by the Fund. A summary plan description for this group insurance policy will be distributed to you, and is also available upon request. Mental Health and Alcohol / Substance Abuse Treatment benefits payable under the Plan, and the disability income benefit and other benefits payable under the Plan, are provided by the Fund. The Plan Document, which includes the Life Insurance and Accidental Death and Dismemberment group insurance policy, is the written document prescribed by law.

Receipt of either this Booklet or the Plan Document does not entitle you to any benefits under the Plan. The eligibility rules described in this Booklet and the Plan Document determine whether you meet the requirements for participation under the Plan. No Participant, beneficiary, Retiree or Covered Persons has a "vested" right to any benefits provided under the Plan.

The Board of Trustees of the Fund, consisting of those persons named above, is the Plan Administrator and the Plan Sponsor. The Board of Trustees has the sole and exclusive right to amend, modify or terminate the Plan, in whole or in part, at any time. The Board of Trustees of the Fund also has the sole and exclusive power and discretion to construe, interpret and apply terms and conditions of the Plan and this Plan Document.

Pursuant to such discretionary authority, the Board of Trustees shall determine all questions arising in the administration, interpretation and application of the Plan, including eligibility for and amounts of benefits available hereunder. All such constructions, interpretations and determinations shall be final, conclusive and binding upon Participants, beneficiaries, Retirees, Covered Persons, employees,

employers, all unions and any other persons or parties dealing with the Fund. Further, all decisions of the Board of Trustees, whether pursuant to the claim appeal process described herein or otherwise, shall be final, conclusive and binding on all parties. If the Board of Trustees does change or interpret any major parts of the Plan, you will be informed of the change.

The Board of Trustees of the Fund is also authorized and empowered generally to do all things, execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Plan. No contributing employer, employer organization or association, labor organization, or any individual employed by one of these organizations has the authority to answer questions or interpret any provisions of this Booklet, the Plan or the Plan Document on behalf of the Fund.

The Fund's employees administer the day-to-day operations of the Plan under the guidance and direction of the Fund's Board of Trustees and the Fund's Executive Director. The Fund's Executive Director generally has the authorities and duties given by the assignment, delegation or direction of the Board of Trustees. The Executive Director, in conjunction with the Board of Trustees, shall have authority to control and manage the operation and administration of the Plan. The Executive Director of the Fund is:

Michael S. Lovely
Wisconsin Health Fund
6200 West Bluemound Road
Milwaukee, WI 53213
(414) 771-5600

The agent for service of legal process for the Fund is the Fund's Executive Director, at the address listed above. Service of legal process may also be made on any Trustee.

A fiduciary under the Plan, including the Fund's Executive Director or the Fund's Board of Trustees, may employ one or more persons to render advice with regard to any responsibility such fiduciary has under the Plan. Specifically, a fiduciary with respect to control or management of the assets of the Plan may appoint an investment manager or managers to manage, including the power to acquire and dispose of, any assets of the Plan. Such appointment shall be accompanied by a written investment policy approved by the Board of Trustees.

WISCONSIN HEALTH FUND
SUMMARY PLAN DESCRIPTION BOOKLET

Table of Contents

I. PLAN BENEFITS FOR YOU, YOUR SPOUSE AND YOUR DEPENDENTS

For Active Participants and their families, the Fund has Plans that offer single or family coverage and different benefit levels (for example: Premier, A1, A2, B, B2 and C1 Plans), depending upon your applicable Collective Bargaining Agreement and your Employer's Participation Agreement with the Fund. Upon retirement, you may be eligible for benefits through similar Plans, as described in this Booklet and the Plan Document. Your individualized At-a-Glance Schedules of Benefits and your Summary of Benefits and Coverage detail your benefit levels, deductibles, co-payments, out-of-pocket maximums and calendar year benefit maximums. According to your Plan, you, your spouse and Dependents may have some or all of the following benefits:

- Medical
- Pharmacy
- Dental
- Vision
- Life Insurance
- Accidental Death and Dismemberment
- Loss of Time (Short Term Disability)

> Your individualized At-a-Glance Schedule of Benefits and your Summary of Benefits and Coverage detail your benefit levels, deductibles, co-payments, out-of-pocket maximums and calendar year benefit maximums. At-a-Glance Schedules of Benefits and a Summary of Benefits and Coverage are available upon request from the Fund.

II. INITIAL ELIGIBILITY AND CONTINUATION OF COVERAGE

This Section explains when you, your Spouse and your Dependents are covered by your Plan and also explains how to maintain your coverage by making Self-Payments in accordance with Plan procedures that meet all requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). This Section also explains how to re-establish eligibility after you have lost coverage.

A. OVERVIEW

1. Participant

You become a Participant when your Employer makes contributions to the Plan on your behalf and you meet the initial eligibility requirements of the Plan, as described herein.

2. Spouse

Your Spouse is the person to whom you are legally married while you are covered under the Plan.

3. Dependent Child

A Dependent child is a child who is either your natural child, adopted child, step-child or child for whom you are the legal guardian, or a child for whom you are legally required to provide medical coverage. Your Dependent child will no longer be eligible for coverage under the Plan upon reaching age 26. A Dependent child who is age 26 and older, and who is physically and/or mentally disabled, may be eligible for coverage upon meeting the requirements described in the Dependent Children Eligibility Summary below.

B. PARTICIPANT ELIGIBILITY SUMMARY

1. Establishment of Initial Eligibility and Coverage

You are covered by the Plan after you establish initial eligibility. Depending on your type and level of coverage under the Plan, initial eligibility is established in one of the following two methods.

a) First, your initial eligibility is established, in general, when your Employer begins making timely contributions to the Plan on your behalf. Specifically, your coverage begins at 12:00am on the Sunday of the first week, or at 12:00am on the first day of the next month, that you first had contributions made to the Plan on your behalf.

b) Second, your initial eligibility is established when you meet one of the following three requirements, depending on your Employer and type of coverage under your Plan:
   1) You have eight (8) consecutive weeks of contributions made on your behalf to the Plan (if your Employer contributes weekly) or two (2) consecutive months of contributions made on your behalf to the Plan (if your Employer contributes monthly); or
   2) You have met the hourly eligibility requirements of your Plan (if your Employer contributes hourly); or
   3) You meet one of the conditions described below under "Immediate Coverage."

   With respect to this second method of establishing initial eligibility, if your Employer makes weekly contributions, your coverage begins the Sunday after the appropriate contributions have been made on your behalf for eight (8) consecutive weeks. And if your Employer makes

monthly contributions, your coverage will begin on the first day of the month after the appropriate contributions have been made on your behalf for two (2) consecutive months. You should refer to your Collective Bargaining Agreement to learn when your Employer is required to begin making contributions on your behalf.

Also with respect to this second method of establishing initial eligibility, you will have immediate coverage in the Plan if you meet any of the following requirements:

1) You return to work with any Employer that makes contributions on your behalf under the Plan within two (2) years of the date your prior coverage under the Plan ended;
2) You are in a group of employees covered by another health and welfare plan and your group begins participating in the Plan; or
3) Your local union health and welfare plan has agreed to reciprocate with the Plan.

Regardless of which method of establishing initial eligibility is used, your eligibility will not be established until you submit proof of insurability that is acceptable to the Fund.

2. Termination of Participant Coverage

In general, your coverage ends when your Employer no longer makes timely contributions to the Plan on your behalf (unless you choose to make Self-Payments, as described below). Specifically, your coverage ends at midnight on the Saturday of the last week, or at midnight on the last day of the month, that you had contributions made to the Plan on your behalf. Your Collective Bargaining Agreement explains how long your Employer must make contributions on your behalf after you have stopped working.

The date that your coverage ends depends on the reason you stopped working, as described below.

a) If you Quit, are Discharged, Laid-off or take a Leave of Absence: Your Employer must make contributions on your behalf through the Saturday of the week, or the last day of the month, that you stop working.
b) If you go on Sick Leave or become totally and permanently Disabled: You may refer to your Collective Bargaining Agreement to learn how long your Employer must continue to make contributions on your behalf, or ask your local union representative how long your Employer must continue to make contributions on your behalf.
c) If your employer files bankruptcy, your coverage will end at midnight on the Saturday of the week (if your Employer contributes weekly), or on the last day of the month (if your Employer contributes monthly), that your Employer's bankruptcy petition is filed.
d) If your Employer fails to make timely contributions on your behalf at the rate(s) designated in writing by the Fund, the Fund may, in its sole discretion, terminate coverage for the Employer's Participants (including you) upon reasonable written notice to the Employer and its Participants, with such notice not less than thirty (30) days.

Your coverage will also end on the date you become covered as a result of military service, except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (described below in this booklet).

3. Continuing Coverage

If your employer stops making contributions on your behalf, your coverage will continue if you make Self-Payments and meet the requirements described in Section II.E. below entitled "Continuation of Coverage Under COBRA: Self-Payments."

In addition, depending on your Employer and type of coverage under the Plan, your coverage may continue based on the number of "banked" dollars accrued by you prior to termination of your coverage. Participants are encouraged to contact the Fund's Customer Service Department at 1-888-208-8808 for specific information regarding the Fund's policy on this type of continuing coverage. The existence and length of any continuing coverage based on accrued "banked" dollars shall be determined in the Fund's sole discretion.

4. Loss of Time Disability Coverage

If you are eligible for Loss of Time Disability Benefits, you, your Spouse and your Dependent children may have health care coverage under the Plan for certain specified amounts of time. Refer to Section V. B. herein entitled "Loss of Time Disability Benefits" for details.

5. Certificates of Creditable Coverage

Any time you lose coverage, the Fund will send a certificate documenting up to 18 months of coverage under the Plan. The certificate is required by the Health Insurance Portability and Accountability Act ("**HIPAA**"), and if you or a Dependent becomes covered under another group health plan, the length of coverage under this Plan can be used to reduce any pre-existing condition time limits imposed by the new plan. The Fund sends a certificate when your eligibility terminates, either as a result of a COBRA qualifying event or other causes. A second certificate is sent when your COBRA continuation coverage ends. A copy of the last certificate issued, updated to show any additional coverage, can also be requested within the 24 months immediately following the date Plan coverage ends. Each certificate shows, among other things, the persons covered by the Plan and the length of coverage applicable to each. If you have questions about the right to receive a certificate of creditable coverage or the information it contains, you may contact the Fund's Customer Service Department at 1-888-208-8808.

C. SPOUSE ELIGIBILITY SUMMARY

1. Establishment of Spousal Coverage

Generally, your Spouse will start coverage in the Plan at the same time you do. If you marry after your Plan coverage starts, your Spouse will be covered on the day you get married. You must notify the Fund regarding your Spouse within thirty (30) days of the date of your marriage. If the Fund does **not** receive a completed enrollment change form within thirty (30) days of the marriage, the change will not be considered until the next annual open enrollment. Your Spouse's eligibility will not be established until you submit proof of insurability that is acceptable to the Fund.

2. Termination of Spousal Coverage

Your Spouse is no longer covered by the Plan at midnight on the Saturday of the week (if your Employer contributes weekly), or on the last day of the month (if your Employer contributes monthly), in which any of the following happen:

a) Your coverage ends; or
b) Your Spouse becomes covered as a result of military service.

In the event of divorce or legal separation, coverage for your Spouse will end on the earlier of the date of your legal separation or the date of your divorce. The Fund must be notified within sixty (60) days of the date of divorce or legal separation. If you or your Spouse fails to provide notice during this 60-day period, your Spouse will NOT be offered the option to elect COBRA continuation coverage.

D. DEPENDENT CHILDREN ELIGIBILITY SUMMARY

1. Establishment of Dependent Child Coverage

Generally, your Dependent child will start coverage in the Plan at the same time you do. If you become responsible for a child while covered under the Plan, coverage for the child will start at birth, adoption, or upon the date you become legally obligated to provide coverage for the child, as applicable. You must notify the Fund within thirty (30) days of the birth, adoption, or the date you become legally obligated to provide coverage for the child, as applicable. If the Fund does **not** receive a completed enrollment change form within thirty (30) days of the events described herein this paragraph, the change will not be considered until the next annual open enrollment. Your Dependent's eligibility will not be established until you submit proof of insurability that is acceptable to the Fund.

2. Termination of Dependent Child Coverage

Your Dependent child is no longer covered by the Plan at midnight on the day in which any of the following happen:

a) Your coverage ends;
b) Your child becomes covered as a result of military service;
c) You are no longer legally obligated to provide coverage for the child; or
d) Your child reaches age 26.

If any of the events described above in a) through d) occur, the Fund must be notified within sixty (60) days of the event. If the Fund does **not** receive notice during this 60-day period, your Dependent child will NOT be offered the option to elect COBRA continuation coverage.

3. Establishment of Coverage for Permanently Disabled Adult Dependent Children Age 26 and Over

If you have a permanently mentally disabled adult child age 26 or older, or a permanently physically disabled adult child age 26 or older, the permanently disabled adult child is eligible for benefits if he or she meets <u>all</u> of the following:

a) Is dependent on you for full support; and
b) Meets all eligibility requirements for natural children, except the age requirement; and
c) Was covered under the Plan as your Dependent before reaching age 26; and
d) Became permanently disabled, either mentally or physically, before reaching age 26.

To establish coverage for a permanently disabled adult child age 26 or older, you must file written notice of the child's permanent disability with the Fund within sixty (60) days of the disabled child's 26th birthday. From then on, you must file written notice of the child's permanent disability with the Fund at time intervals to be reasonably determined by the Fund. The written notice must include a doctor's statement (on letterhead stationery) detailing the severity of your child's permanent disability. Other Proof of Eligibility may from time to time be reasonably required by the Fund.

4. Termination of Coverage for Permanently Disabled Adult Dependent Children Age 26 and Over

In addition to those events described above in Section II, D, 2, a) through d), coverage will terminate once the permanently disabled adult child becomes eligible under another group health plan, or becomes capable of self-support.

E. CONTINUATION OF COVERAGE UNDER COBRA: SELF-PAYMENTS

If your employer is no longer required to make contributions on your behalf, you, your covered Spouse and Dependent children will normally lose the Plan coverage unless Self-Payments are made. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**") you, your covered Spouse or Dependent children can elect to temporarily continue to participate in the Plan with respect to your medical, dental, vision and pharmacy benefits, if you, your covered Spouse or Dependent children would otherwise lose coverage when a "qualifying event" occurs. "Qualifying Events," for purposes of this benefit section only (i.e., Continuation Of Coverage Under COBRA: Self-Payments), are described below.

This continuation coverage is commonly known as COBRA coverage. If coverage under the Plan is modified for all similarly situated Participants, it will also be modified for COBRA participants. Your covered Spouse or children have the right to independently elect COBRA coverage even if you do not elect it.

A Self-Payment is a contribution that you, your Spouse or your Dependent children can make to the Plan to continue coverage. The Plan's Self-Payment Policy meets all requirements of COBRA. It applies only to medical, dental, vision and pharmacy benefits (and only those benefits to which you were entitled prior to your qualifying event), and does not apply to loss of time (short term disability), life insurance or accidental death and dismemberment benefits. Self-Payments can be made for continuation of medical, dental, vision and pharmacy benefits under the Plan, or a "core" plan which includes medical and pharmacy benefits only. Once your selection of a particular coverage is made, you can only change to a lower level of coverage, unless you return to employment and contributions are made on your behalf.

1. Qualifying Events

a) Covered employee's termination of employment or reduction in hours. If your employment terminates (for reasons other than gross misconduct) or if your hours are reduced to the point where you would ordinarily lose coverage under the Plan, you, your covered Spouse and children may elect COBRA coverage for up to eighteen (18) months from the date of the qualifying event. However, your receipt of vacation benefits, accrued banked hours or severance pay does not constitute a new qualifying event and does not result in an extended COBRA coverage period.

b) Covered employee's death. If you die while you are employed and your Dependents are covered by the Plan, then your Spouse and any children may elect COBRA coverage for up to thirty-six (36) months from the date of your death. If you have no Spouse, or your Spouse is not eligible for COBRA coverage, your children may elect COBRA coverage for up to thirty-six (36) months from the date of your death.

c) Divorce or legal separation. If your divorce or legal separation occurs prior to termination of employment, your Spouse and any children may elect COBRA coverage for thirty-six (36) months from the date of the divorce or legal separation. If your divorce or legal separation occurs while COBRA coverage is in effect, only your covered Spouse and any child(ren) may elect to extend coverage for up to thirty-six (36) months from the date of the original qualifying event. (See Multiple Qualifying Events below.)

d) Child is no longer a Dependent. If your child loses eligibility under the Plan because he or she ceases to be a Dependent as defined by the Plan, your child may elect COBRA coverage for up to thirty-six (36) months.

e) Medicare entitlement. After your COBRA election date, if you become entitled to Medicare as your primary coverage, then your Spouse and/or your child(ren) may elect COBRA coverage for up to thirty-six (36) months. If your Spouse is not entitled to COBRA coverage, your child(ren) may continue COBRA coverage for up to thirty-six (36) months after your COBRA election date.

For these qualifying events, you, your Spouse or children must pay up to 102% of the full cost of the coverage, or up to 150% of the full cost of the coverage, as applicable.

2. Multiple Qualifying Events

If your Spouse and/or Dependents have another qualifying event while already on COBRA coverage due to your employment termination or reduction in hours, they may elect to extend the period of COBRA coverage for up to a maximum of thirty-six (36) months from the date of your employment termination or reduction in hours.

For example, assume that you (or your Spouse or children) elect COBRA coverage because of your employment termination. If you die during the first eighteen (18) months of COBRA coverage, your Spouse and child(ren) could elect to continue COBRA coverage for up to thirty-six (36) months from your date of employment termination. Note however, that a reduction in hours, followed by a termination of employment, does not create another eighteen (18) months of COBRA coverage.

3. COBRA Notices and Establishment of COBRA Coverage

Within fourteen (14) days from when the Fund receives notice of your separation from employment, a continuation notice will be sent to you. If you do not receive the notice, you should contact the Fund.

If a covered Dependent qualifies for COBRA coverage due to a qualifying event such as divorce, legal separation, or ceases to meet the definitions of a Dependent under the Plan, you or your Dependent must notify the Fund to request continuation coverage. This request must be made within sixty (60) days of becoming ineligible. You or your family members will then be sent a continuation notice within fourteen (14) days. If you or your Dependent fails to provide notice of ineligibility during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect COBRA continuation coverage.

After you receive the Plan information, you will have sixty (60) days to make a decision on whether to continue your existing health care coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

Single Coverage vs. Coverage for a Participant with at Least one (1) Covered Dependent. If you have no covered Dependents and you qualify for COBRA coverage due to a qualifying event, you may enroll for Single Coverage. Similarly, if a covered Dependent independently qualifies for COBRA coverage due to a qualifying event such as divorce, legal separation, or ceasing to meet the definitions of a Dependent under the Plan, the covered Dependent may enroll for Single Coverage. However, if you have at least one (1) covered Dependent and you qualify for COBRA coverage due to a qualifying event, and you and at least one (1) of your covered Dependents elect COBRA continuation coverage, you and the covered Dependent(s) will be automatically enrolled for coverage that will apply to you and the covered Dependent(s). (Enrollment for Single Coverage covers you (the employee) only. Your Spouse and/or Dependent children will not be covered if you enroll in Single Coverage. Enrollment for

coverage that will apply to you and the covered Dependent(s) is intended to cover you (the employee), your eligible Spouse (if any) and your eligible Dependent children (if any).)

4. Extension of COBRA Coverage Upon Disability

If you or a covered family member is Disabled under the Social Security Act at any time within the first sixty (60) days of COBRA coverage, you or a covered family member may extend participation under the Plan for up to an additional eleven (11) months for a total of twenty-nine (29) months, by notifying the Fund within sixty (60) days of the date of the Social Security determination of disability and within eighteen (18) months of the original COBRA qualifying event.

The 11-month disability extension also applies independently to each eligible Dependent who is not Disabled and who would otherwise have lost coverage because of the employment termination or reduction in hours.

In the event you or a covered family member no longer qualifies for Social Security disability, you must notify the Fund within thirty (30) days of the date of the final determination. COBRA coverage will then stop.

During the 11-month disability extension you, your Spouse or children must pay up to 150% of the full cost of the coverage.

5. Adding New Dependents

If you have a new child during the COBRA continuation period, your new child is entitled to receive coverage upon his or her birth, adoption, or upon the date you become legally obligated to provide support for the child. You must notify the Fund within thirty (30) days of the birth, placement for adoption, or judgment, and you will not have to wait until the next annual open enrollment period to enroll your child.

However, the group of qualified beneficiaries closes as of the day before the qualifying event. In other words, newborn and adopted children who subsequently join the family are not qualified beneficiaries and are not eligible for extended coverage if the qualified beneficiary experiences a second qualifying event.

6. Adding Spouses

If you get married during the COBRA continuation period, your new Spouse is entitled to receive coverage upon the date you become legally married. You must notify the Fund within thirty (30) days of the marriage, and you will not have to wait until the next annual open enrollment period to enroll your new Spouse.

However, the group of qualified beneficiaries closes as of the day before the qualifying event. In other words, new Spouses who subsequently join the family are not qualified beneficiaries and are not eligible for extended coverage if the qualified beneficiary experiences a second qualifying event

7. Making Self-Payments

Generally, you, your Spouse or your Dependent children can make Self-Payments as long as you are covered under the Plan on the day before the event that causes you to lose coverage. However, no one can continue to make Self-Payments if that person either becomes:

a) Covered under any other employee welfare benefit plan providing medical care that does not contain any exclusion or limitation with respect to any pre-existing condition of the person seeking continued coverage through Self-Payments; or
b) Entitled to Medicare benefits.

8. How To Make Self-Payments

The election and payment periods for Self-Payments are determined by the event that results in loss of coverage under the Plan. You must notify the Fund of your desire to make Self-Payments within thirty (30) to sixty (60) days depending on the event that caused you to lose coverage in the Plan. (Refer to the chart in this Section E for the specific time period corresponding to each event which causes you to lose coverage).

Important: All Self-Payments must be continuous and be made in weekly or monthly installments, as directed by the Fund. The initial Self-Payment must apply to the week or month beginning immediately after the date your coverage ended and extend up through the end of the month preceding the month in which the Self-Payment is made. After the initial Self-Payment, all Self-Payments must be received by the Fund no later than thirty (30) days from the date coverage last ended. The chart in this Section E outlines the qualifying event and the time period you, your Spouse or your Dependent children have to elect and make Self-Payments.

9. Termination of COBRA Coverage

COBRA coverage through the Fund will end earlier than the 18-, 29-, or 36-month periods in any of the following circumstances:

a) Payment of any required contribution is not received within thirty (30) days after the due date;
b) After electing COBRA coverage, you or your Dependent(s) becomes covered by any group health plan that does not contain a pre-existing condition exclusion or limitation that applies to you or your Dependents (or you or your Dependent(s) becomes covered by any group health plan that, due to HIPAA, has pre-existing condition limitations or exclusions that no longer apply);
c) All employer-provided group health plans are terminated and not replaced;
d) All employer-provided group health plans are terminated and replaced by other group health plan(s) covering similarly situated non-COBRA beneficiaries, in which case the succeeding group health plan will be responsible for your COBRA coverage;
e) You or your Dependent(s) is on an 11-month disability extension and Social Security determines that you or your Dependent(s) is no longer Disabled;
f) The date your employer ceases to maintain any group health plan; or
g) You or your Dependent(s) first becomes Medicare entitled after your or your Dependent's(s') COBRA coverage qualifying event.

Once COBRA coverage is cancelled, it will not be reinstated.

10. The Cost for COBRA Coverage

You will be charged the full cost of the Plan coverage, plus a 2% administrative charge. However, during any additional 11-month continuation due to disability under Social Security, the cost of coverage will be up to the full cost of the group plan coverage plus 50%. Specific cost information will be provided on an individual basis at the time of the qualifying event.

You may make any required payment for the COBRA coverage on a weekly or monthly basis, as determined by the Plan. Your first payment will cover the period from the date your coverage terminates until the date you elect coverage, and is due within 45 days of the election date. The Plan may delay processing of claims or terminate coverage during the COBRA election and payment periods until all outstanding premium payments are received. When all premium payments are received, coverage will be reinstated and claims paid retroactively. However, any providers who contact the plan to confirm coverage for you or your Dependent during the election period will be informed that you have not yet made the election, but that you will have coverage retroactively if your COBRA election is made within the 60-day period.

COBRA coverage may be provided in various types (e.g., single, family, employee + one, etc.) depending on your Plan coverage before COBRA, and each type of COBRA coverage will have corresponding differences in premium. If your COBRA coverage is provided based on a "composite" rate, only one premium rate will be given, regardless of whether the coverage is provided for one or more persons.

Event Which Causes Loss of Coverage	Maximum Time Period For Making Self-Payments*		Number of Days From Event Within Which Fund Must Be Notified	Election Period From Receipt Of Notice	Initial Payment Due From Date Of Election
	Participant	Spouse or Dependent Child			
Termination of Employment of Participant	18 months	18 months	30 days	60 days	45 days
Reduction in Hours of Participant	18 months	18 months	30 days	60 days	45 days
Sick Leave of Participant	18 months	18 months	30 days	60 days	45 days
Layoff of Participant	18 months	18 months	30 days	60 days	45 days
Unemployment of Participant Due To Filing of Bankruptcy Petition by Employer	18 months	18 months	30 days	60 days	45 days
Suspension of Benefits	18 months	18 months	30 days	60 days	45 days
Covered Participant's Death	N/A	36 months	60 days	60 days	45 days
Divorce or Legal Separation (if results in Loss of Coverage)	N/A	36 months	60 days	60 days	45 days
Covered Participant's Entitlement to Medicare	N/A	36 months	60 days	60 days	45 days
Loss of Dependent Coverage	N/A	36 months	60 days	60 days	45 days
Note that an eighteen (18) month period will be extended by eleven (11) months for a total of twenty-nine (29) months in the event of a disability determination by the Social Security Administration, and to thirty-six (36) months if a second qualifying event occurs within the initial eighteen (18) month (or twenty-nine (29) month, as applicable) period.					

III. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

Depending on your type of coverage under the Plan, you, your Spouse and Dependent children may have a Life Insurance Benefit, and you may have an Accidental Death and Dismemberment Insurance Benefit. This Section describes the Life Insurance Benefit for you, your Spouse and Dependent children, as well as describing your Accidental Death and Dismemberment Insurance Benefit. Life Insurance and Accidental Death and Dismemberment benefits payable under the Plan are provided through a policy of group life insurance issued by a licensed life insurance carrier selected by the Fund. The Fund has taken great care to describe below the Life Insurance and Accidental Death and Dismemberment benefits available to you, your Spouse and your Dependents. However, this Booklet is not meant to interpret, extend or change in any way the terms and conditions of the group life policy. If any information in this Booklet conflicts with the group life policy, the group life policy will control. The terms of the group life policy are further described in the life insurance carrier's summary plan description, which was provided to you at your time of enrollment. Additional copies of the life insurance carrier's summary plan description can be obtained by contacting the Fund.

A. LIFE INSURANCE BENEFIT

In the event of your death, the Plan provides a lump sum Life Insurance Benefit to your beneficiary. And, depending on the Plan, in the event of the death of your Spouse or a Dependent child, a lump sum Life Insurance Benefit is provided to you.

1. Amount of Benefit

The amount of the Life Insurance Benefit will be determined by the Plan. Your At-a-Glance Schedule of Benefits shall describe the necessary details. Note the following:

a) Dependent Children: There is no life insurance benefit payable to you upon the death of a Dependent child age 26 or older.

b) Beneficiaries: Participants must always have a named beneficiary (or beneficiaries) on file with the Fund. For the procedure to name a beneficiary (or beneficiaries), see the section entitled "Beneficiaries" below.

2. Payment of Benefit

The Life Insurance Benefit will be paid according to the group life policy issued to the Fund. The terms of the group life policy are summarized in the life insurance carrier's summary plan description, which was provided to you at your time of enrollment. Additional copies of this benefit booklet may be obtained by contacting the Fund.

B. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (PARTICIPANT ONLY)

In the event you die or suffer a loss due to an accident, the Plan provides for an Accidental Death and Dismemberment Benefit. The Fund does not administer this benefit. For further details you should consult the summary plan description issued by the life insurance carrier. Copies of this benefit booklet may be obtained by contacting the Fund

1. Amount of Benefit

The amount of the Accidental Death and Dismemberment Benefit will be determined according to the Plan. Your At-a-Glance Schedule of Benefits shall describe the necessary details.

2. Payment of Benefit

The Accidental Death and Dismemberment Benefit will be paid to you according to the summary plan description issued by the life insurance carrier. The life insurance company providing benefits reserves the right to require you to have a physical examination in connection with a claim for accidental dismemberment. The Accidental Death Benefit, if applicable, will be payable to your beneficiary in addition to the Life Insurance Benefit.

> Example: Ed, a Participant, was killed in a car accident. Because his death was accidental, his beneficiary received $50,000 in Life Insurance Benefits and $50,000 in Accidental Death Benefits for a total of $100,000 in benefits.

Note that all benefits for accidental dismemberment or loss of sight will be paid through the life insurance after the life insurance carrier receives satisfactory proof of loss.

C. Beneficiaries

You are automatically the beneficiary of the Life Insurance Benefit for your Spouse and Dependent children. No one else may be named as beneficiary.

In the event of your death, your beneficiary will receive the Life Insurance Benefit or Accidental Death Benefit or, if eligible, both these benefits. You may name anyone that you want as your beneficiary. It is extremely important, however, that you name someone.

A person becomes your beneficiary only if you have named that person as your beneficiary on your Participant Information form. You may change your beneficiary at any time by filling out a Life Insurance Beneficiary Designation form, which is available through the Fund. You are strongly urged to have a completed form specifying your beneficiary on file with the Fund to avoid disputes regarding your proper beneficiary.

D. Claim Filing for Life Insurance and Accidental Death and Dismemberment Benefits

All claims for the Life Insurance Benefit and Accidental Death and Dismemberment Benefits must be filed within one (1) year of the date of loss. You should file claims for these benefits through the Fund. Participants may contact the Fund for information describing the items you or your beneficiary will need to file a claim for these benefits. Also, upon request, the life insurance carrier will notify you of the information, such as a medical examination, which is required for submission and payment of a valid accidental dismemberment benefit claim.

IV. THE PLAN FOR ACTIVE PARTICIPANTS

A. THE PLAN

The Plan is designed to allow you and your Dependents a three-tiered option for accessing health, dental, and pharmacy care benefits. First, the on-site facilities located at 6200 West Bluemound Road in Milwaukee, Wisconsin represent the most affordable option. Services received on-site are provided to you at a significantly reduced cost. Under the medical plans, services performed on-site are offered at inexpensive Co-pays and are not subject to the Deductible and Co-insurance amounts specific to each benefit design. The dental plans are also enhanced to provide more coverage on-site, and the prescription drug Co-pays are lower for drugs obtained from WHF's on-site pharmacy.

Second, in addition to the efficient, quality care offered at the WHF on-site facilities, the Plan provides healthcare benefits for services provided through some of the largest Preferred Provider Organization ("**PPO**") networks in the area. These PPOs offer you broad choices of physicians and Hospitals that have been chosen based on quality and affordability. You can access your healthcare benefits in the traditional manner by choosing providers within the appropriate network, and satisfying the Plan Deductible and Co-insurance amounts. Listings of in-network providers are available from WHF upon request and without charge.

The third tier of benefits is available for services performed by out-of-network providers. However, your benefits with this option may be significantly reduced. Benefits for services provided by out-of-network providers may be reduced due to Plan penalties and payment reductions based on Usual and Customary Charges. In some cases, benefits may even be denied if out-of-network providers are used in non-emergency situations.

If the PPO networks provided by the Plan do not include in-network providers for your particular medical need within a thirty (30) mile radius of your home address, the Plan will provide benefits for the rendition of covered services by out-of-network providers without a resulting reduction in Plan benefits. This allowance of in-network benefit levels for covered services provided by out-of-network providers applies to <u>medical</u> benefits only.

It is very important that you understand these variations in levels of coverage. You must pay special attention to the At-a-Glance Schedules of Benefits pertaining to your specific plan.

1. Preferred Provider Organization Defined

A PPO or preferred provider network is a group of physicians and medical facilities (such as Hospitals) that agree to provide health care services at discounted rates. Providers occasionally join and/or drop participation in the network. To ensure you receive the in-network level of benefits, you should always ask the health care providers if they still belong to the network or check with the PPO network itself. Current network directory information is available, without charge and upon request, from the Fund's Customer Service Department at 1-888-208-8808.

Also, regardless of whether or not the Wisconsin Health Fund Medical and Dental Centers are designated as in-network providers, you may use the Wisconsin Health Fund Medical and Dental Centers and enjoy the maximum level of in-network benefits offered under the Plan.

2. Costs When You Choose to Receive Care from Out-of-Network Providers

The Plans covers both in-network and out-of-network services at different levels, based on whether the provider (such as a doctor or Hospital) is an in-network provider or an out-of-network provider. We want to help you understand how much we will pay for care received from an out-of-network provider. We also want to help you understand how much you may need to pay if you chose to receive care from an out-of-network provider.

In-Network Providers. In-network providers have contracts in place with our PPO networks. These contracted providers agree to how much they will charge you for covered services. That amount is often less than what those providers would charge if they were not in our PPO networks. Most of the time, it costs you less to use providers in our PPO networks, in part because these in-network providers agree to not bill you for any amount over their contract rate. All you have to pay is your Co-Payment, Co-Insurance, and any Deductible amount.

Out-of-Network Providers. Out-of-network providers do not have contracts in place with our PPO networks. This means that there are no contracts in place for reduced or discounted rates with that provider. As a result, we do not know exactly how much an out-of-network provider will charge you. If you choose to receive care from an out-of-network provider, we may pay some of that out-of-network provider's bill. However, most of the time, you will pay more money out of your own pocket if you choose to receive care from an out-of-network provider.

Your Costs. Your out-of-network provider sets the rates charged to you. These rates may be higher (sometimes much higher) than what the Plan recognizes or allows. Your out-of-network provider will likely bill you directly for the dollar amount that the Plan does not recognize or allow. You will also likely pay higher Co-Payments, Co-Insurance, and Deductible amounts under the Plan if you choose to receive care from an out-of-network provider.

When you choose to receive care from an out-of-network provider, we pay an amount for your health care based on a percentage of what Medicare would pay for that same care. You can call the Fund's Customer Service Department at 1-888-208-8808 to find out the percentage the Plan uses to reimburse out-of-network providers. You can also ask your out-of-network provider for an estimate of your share of the costs for any out-of-network services you may be planning.

Important: This means that you will be fully responsible for paying everything above the amount that the Plan recognizes or allows for a service or procedure provided by your out-of-network provider.

3. Highlights and Definitions

Deductible. A Deductible is the amount of eligible medical expenses you and/or your Dependent must pay each Calendar Year before the Fund begins to pay any benefits. There is an individual Deductible and a family Deductible. After the Deductible has been met, the Fund will begin paying benefits according to the benefit level outlined in your At-a-Glance Schedule of Benefits. The Deductible applies to both in-network and out-of-network benefits.

As an added benefit to you for receiving care at the Wisconsin Health Fund Medical and Dental Centers, the Deductible **does not** apply when you receive medical or dental care at the Wisconsin Health Fund Medical and Dental Centers.

Co-insurance. After the Deductible is met, the Fund will begin sharing the cost of covered medical expenses with you. The portion or percentage you pay is called Co-insurance. You will usually receive a bill from the health care provider for the amount of Co-insurance you owe after the claim has been submitted and processed.

As an added benefit to you for receiving care at the Wisconsin Health Fund Medical Center, the Co-insurance amount **does not** apply when you receive **medical** care at the Wisconsin Health Fund Medical Center. Note that the Co-insurance amount **may** apply when you receive **dental** care at the Wisconsin Health Fund Dental Center.

Out-of-pocket maximums. Your Plan has out-of-pocket maximums applicable to your medical (including Mental Health and substance abuse treatment) and prescription drug benefits. The out-of-pocket maximum is the highest amount you must pay each Calendar Year before the Plan begins paying 100% of eligible expenses. The following expenses will not count toward your out-of-pocket maximums:

a) Co-insurance and penalties, if any, for using an out-of-network provider;
b) Any amounts charged for failing to pre-certify or pre-authorize treatment; and
c) Any amounts paid for non-covered services.

However, Deductible and Co-payment amounts do apply to your out-of-pocket maximums.

Usual and Customary Charge. The Usual and Customary Charge is the maximum amount that the Plan will consider for payment for a particular item, service or treatment. When you file a claim, the Fund will compare the charge for each treatment with the charge for the same treatment made by other health providers. The amount the Plan will pay will be based on the amount most often charged by the majority of health providers for that treatment.

The charges for care provided to you will probably be well within the range of current fees. If, however, your health care provider's charge is more than the Usual and Customary Charge determined by the Fund, you will have to pay the difference. The Usual and Customary Charges are reviewed and updated periodically.

Any amount over the Usual and Customary Charge is not payable by the Plan, and if the actual charge exceeds the Usual and Customary Charge, the Plan will pay the benefits based on a percentage of the Usual and Customary Charge (not a percentage of the actual charge).

4. Benefit "Buy-Ups" and "Buy-Downs"

Depending upon your type of coverage under the Plan, the Plan may allow you to voluntarily select enhanced or reduced coverage in exchange for a larger or smaller payroll deduction, if any (a benefit "buy-up" or "buy-down," respectively). For example, you may elect to move from the B plan to the C1 plan if you are willing to accept lesser coverage in exchange for smaller payroll deductions. Your Pharmacy, Dental, Vision, Loss-of-time, and Life benefits, if applicable, would not be affected by this election.

If this choice is available to you, examine the benefits carefully and select the plan that best suits your family's needs. Election forms are available from the Fund, and every November during annual open enrollment you will have an opportunity to switch plans. Changes made during annual open enrollment will become effective on the first day of the January billing cycle. In addition, you may change plans within thirty (30) days of a "Qualifying Event." A "Qualifying Event" for purposes of this benefit

section only (i.e., benefit "Buy-Ups" and "Buy-Downs") is defined as marriage or divorce; birth, adoption, or legal guardianship of a child; the loss or addition of other coverage; or death.

If you choose to "buy-up" or "buy-down" based upon a "Qualifying Event" as defined in the above paragraph, you will be required to stay with the elected plan until the second annual open enrollment period after your election is made.

5. "Opting-Out" and "Opting-In" of Benefits

Depending upon your type of coverage under the Plan, the Plan may allow you to voluntarily waive your coverage ("opt-out" of coverage). Your Pharmacy, Dental, Vision, Loss-of-time, and Life benefits, if applicable, will also be waived by this election. Election forms are available from the Fund, and you may be able to "opt-out" of coverage upon submission of this form. And under certain circumstances, even if you originally waived or "opted-out" of coverage, you may in the future enroll or re-enroll in coverage ("opt-in" coverage).

However, if you do not enroll for or opt-out of coverage within thirty (30) days of the date you first become eligible for benefits, the Fund will automatically enroll you in coverage that will apply to you and at least one (1) covered Dependent.

Participants can only waive coverage ("opt-out" of coverage) and/or enroll or re-enroll in coverage ("opt-in coverage") at the following times:

a) During your initial open enrollment period;
b) During your annual open enrollment period; or
c) During your "Special Enrollment Period."

"Special Enrollment Periods," for purposes of this benefit section only (i.e., "Opting-Out" and "Opting-In" of Benefits) are described below. If the Fund does not receive a completed form electing to opt-in or opt-out of coverage within the initial open enrollment period, an annual open enrollment period or the Special Enrollment Period, as applicable, your election will not be considered until the next annual open enrollment period. You should notify your employer of the change in coverage so that the appropriate contribution rate will become effective.

The following are the "Special Enrollment Periods" that may allow waiver of coverage ("opt-out" of coverage) and/or enrollment or re-enrollment in coverage ("opt-in coverage"). Each Special Enrollment Period lasts only thirty (30) days from each event described below:

a) Marriage;
b) Birth, adoption, or legal guardianship of a child;
c) Loss of other insurance coverage (you must submit, along with a completed enrollment form, proof that the other coverage has terminated);
d) Divorce; or
e) Death of your spouse.

If you waive the right to coverage through the Plan, you must declare your reason for waiving coverage. Upon any subsequent enrollment or re-enrollment during an annual open enrollment period, you and your Dependents will be considered "late enrollees" and you may be asked to provide health status information for purposes of group rate setting.

6. Selecting Single or Family Coverage and Annual Open Enrollment

You must enroll for Single Coverage ("Single Coverage") or coverage for you and at least one (1) covered Dependent ("Family Coverage") within thirty (30) days of the date you first become eligible for benefits. "Family Coverage" includes different types of coverage, such as family, employee + one, employee + children, etc., depending on your applicable Plan. Enrollment for Single Coverage covers you (the employee) only. Your Spouse and/or Dependent children will not be covered if you enroll in Single Coverage. Enrollment for Family Coverage is intended to cover you (the employee), your eligible Spouse (if any) and your eligible Dependent children (if any).

If you do not enroll for or opt-out of coverage during this thirty (30) day period, you will automatically be enrolled for Family Coverage.

During November of each year, the Fund offers an annual open enrollment period during which you have the option of changing from Single to Family Coverage, Family to Single Coverage, or making changes to an existing Family Coverage. Any changes made during the annual open enrollment period will become effective on the first day of the January billing cycle. You may also change from Family to Single Coverage, or vice versa, or make changes to an existing Family Coverage, if a "Qualifying Event" occurs. "Qualifying Events," for purposes of this benefit section only (i.e., Selecting Single or Family Coverage and Annual Open Enrollment), are described below.

Changes in coverage can only be made during annual open enrollment periods or within thirty (30) days of a Qualifying Event. The Fund must receive a completed enrollment change form within thirty (30) days of a Qualifying Event. The change will become effective on the date of such event. You should notify your employer of the change in enrollment so that the appropriate contribution rate will become effective. If the Fund does not receive a completed enrollment change form within thirty (30) days of the Qualifying Event, the change will not be considered until the next annual open enrollment.

Also, if you are currently under Family Coverage, and wish to enroll additional Dependents for immediate coverage or terminate the coverage of one or more Dependents while maintaining Family Coverage, you must submit an enrollment change form within thirty (30) days of the Qualifying Event. If the Fund does **not** receive a completed enrollment change form within thirty (30) days of the Qualifying Event, the change will not be considered until the next annual open enrollment.

The following are the "Qualifying Events" that may allow or require changes from Single to Family Coverage, Family to Single Coverage, and changes to an existing Family Coverage. Remember that to be considered for immediate coverage, the Fund must receive the necessary enrollment change forms within thirty (30) days of each Qualifying Event.

a) **Marriage.** You get married and want coverage for your Spouse. You may add the new Spouse and any newly acquired qualified Dependents, as long as the necessary documents are supplied and all eligibility requirements are met.
b) **Birth or Adoption of, or Legal Obligation to Provide Coverage for, a child.** You become a parent or legal guardian of a child. You may add the new Dependent(s). All Dependent guidelines described in this Booklet must be met for a Dependent to qualify for coverage.
c) **Loss of Other Insurance Coverage.** If you initially enrolled for Single Coverage, and then your Spouse or a Dependent child later experiences a loss of health coverage due to layoff, termination of employment or change in employment status, you may apply for Family Coverage. You must submit, along with a completed enrollment form: (1) evidence that the

other coverage has terminated; and (2) necessary documentation required for Spouse and Dependents.

d) **Loss of Dependent Status.** If you are maintaining Family Coverage due to a Dependent child, you may apply for Single Coverage if: (1) you are no longer legally responsible for providing coverage for the child; (2) the child reaches age 26; or (3) the child becomes eligible for employment-based coverage.
e) **Divorce.** If you become divorced you must discontinue coverage of the former Spouse. If you are required to maintain coverage of your Dependent children, you must remain under the Family Plan.
f) **Death.** If your Spouse or a Dependent dies, you must notify the Fund that the death has occurred.

B. THE WISCONSIN HEALTH FUND MEDICAL, PHARMACY AND DENTAL CENTERS

Covered Persons can maximize their benefits, and lower their out-of-pocket expenses, by receiving care at the Wisconsin Health Fund Medical and Dental Centers, located at 6200 W. Bluemound Road in Milwaukee, Wisconsin. The Wisconsin Health Fund Medical Center offers primary and pediatric care, OB/GYN services and many other areas of specialty care. It also offers on-site laboratory facilities, on-site physical therapy, on-site chiropractic services, on-site massage therapy and many other on-site services. The Wisconsin Health Fund Dental Center offers a wide range of dental services including but not limited to crowns, bridges, complete and partial dentures, endodontic services, periodontal ("gum") therapy, oral surgery and cosmetic treatment. Your individualized At-a-Glance Schedule of Benefits contains details regarding specific benefit levels, Deductibles, Co-payments, out-of-pocket maximums and Calendar Year Benefit Maximums.

1. Making Appointments For Care at the Wisconsin Health Fund Medical and Dental Centers

Covered Persons can make appointments for care at the Wisconsin Health Fund Medical and Dental Centers by calling (414) 771-5600 or (800) 524-3538. However, if you cannot attend your appointment, you must cancel it at least 24 hours in advance or be required to pay a charge.

2. Referrals Outside the Wisconsin Health Fund Medical and Dental Centers

In some instances, you may need to be referred outside the Wisconsin Health Fund Medical and Dental Centers for specialty care. If this is the case, you will receive a referral from the Wisconsin Health Fund Medical and Dental Centers, and you will be subject to the regular Co-insurance and Deductible obligations under the Plan.

3. Good Cause Termination From Using the Wisconsin Health Fund Medical, Pharmacy and Dental Centers

Upon "good cause" (sufficient to the Trustees in their sole discretion), the Fund may terminate your right to receive care at the Wisconsin Health Fund Medical and Dental Centers. Examples of "good cause" include, but are not limited to, the following:

a) Failure to make payment to the Fund within thirty (30) days of billing for non-covered services;
b) Failure to make payment to the Fund within thirty (30) days of billing of patient financial liabilities required for covered services;
c) Fraud or other misrepresentation by you, your covered Spouse and/or Dependent;

d) Theft of property from the Fund or Wisconsin Health Fund Medical and Dental Centers;
e) Physical abuse or verbal abuse (e.g., threats of violence, litigation, etc.) of Wisconsin Health Fund Medical or Dental Center personnel or patients, other Participants or beneficiaries;
f) Chronic refusal to follow Fund physician's recommendations for health care; and/or
g) Other acts determined to constitute “good cause" for termination in the Trustees’ sole discretion.

V. COVERED BENEFITS

Your Plan has a number of benefits. For example, there is a benefit that pays your hospital expenses and another that covers the doctor's charges for surgery. These benefits and others are explained in this Section V. You can obtain additional information regarding benefits for specific medical tests, devices and procedures by contacting the Fund.

A. COVERED BENEFIT DEFINITIONS

1. Pre-Certification of Benefits

Before you go into a Hospital, hospice or skilled nursing facility for any treatment, including pregnancy, you must pre-certify care by calling the appropriate number listed on your Wisconsin Health Fund medical identification card. If it is not an emergency, you must call to pre-certify at least five (5) business days prior to the related admission. In an emergency situation, you must call (or have someone else call) the Fund within 48 hours after admission. If you fail to obtain Pre-Certification, you will be responsible for paying a penalty.

2. Pre-Determination of Benefits

A Pre-Determination of Benefits ("**PDB**") is a request by you for the Fund to advise you of the benefits the Plan will pay on a claim before you receive treatment. In some cases (see below), you are required to file a PDB before actually having the treatment performed.

While your doctor may feel a certain treatment or certain amount of treatment is Medically Necessary, this same treatment may not necessarily be covered under the Plan. A PDB will safeguard you against learning that the Plan will not pay for treatment or a portion of treatment after it has been received.

A PDB and pre-approval by the Fund are always required for the following treatments:

a) Therapy and nursing services provided in the home;
b) Admission to the Cardiac Rehabilitation Units of a Hospital or rehabilitation facility;
c) All organ transplants; and
d) Rentals or purchases of durable medical equipment (or DME) over $1,000.

You should file the request for a PDB at least one (1) month before the expected date of treatment. This will allow sufficient time for the Fund to review and respond to your request. In cases of true medical emergencies, however, there is no requirement for a PDB to be filed. All requests for PDBs should be directed to Wisconsin Health Fund, 6200 West Bluemound Road, Milwaukee, WI 53213.

B. LOSS OF TIME DISABILITY BENEFITS

Depending on your type of coverage under the Plan, you may have Loss of Time Disability Benefits. Loss of Time Disability Benefits are weekly disability payments made to you if you are Disabled and cannot work. In order to be considered Disabled under this coverage, you must provide proof that you are unable, because of bodily Injury or disease, to perform any and every duty of the occupation in which you were engaged when you became Disabled, and that you are not engaged in any gainful employment. Only you are covered for Loss of Time Benefits. There are no Loss of Time Disability Benefits for your Spouse or your Dependent children.

For disability due to illness or Injury, you can qualify for up to twenty (20) or twenty-six (26) weeks of Loss of Time Benefits, depending on the Plan. For disability due to pregnancy, you can qualify for Loss of Time Benefits for up to six (6) weeks, and longer if pregnancy-related complications arise, once every twelve (12) month period. For disability due to Mental Health or substance abuse reasons, you can qualify for Loss of Time Benefits for up to four (4) weeks every twelve (12) month period.

To qualify for Loss of Time Benefits, you must be employed by a participating Employer, eligible based on employer contributions and covered by the Plan when you become injured, ill or unable to work due to pregnancy. To receive Loss of Time Benefits, you must be under the care of a doctor and be Disabled as a result of a non-work related Injury or illness, or be under the care of a doctor and unable to work due to pregnancy.

You, your Spouse and your Dependent children have full health care coverage in the Plan for a maximum of six (6) weeks every twelve (12) month period if you are eligible to receive Loss of Time Disability Benefits. COBRA Self Payments are available after the six (6) weeks. In some instances, your employer may be required to make additional payments on your behalf. Participants may contact their local union representative to see if this applies to their particular situation.

1. Establishment of Loss Of Time Benefits

Your Loss of Time Benefits will begin according to the following:

a) If you are Disabled because of Pregnancy or an Injury: If you received medical treatment within one (1) day before, or three (3) days after the date of disability specified by the doctor, your Loss of Time Benefits will be paid from the date of disability established by your doctor. Otherwise, your Loss of Time Benefits are paid from the first date of medical treatment following the date you were Disabled.

b) If you are Disabled because you are ill: If you received medical treatment within one (1) day before or three (3) days after the date of disability specified by the doctor, your Loss of Time Benefits will be paid on the eighth (8^{th}) consecutive day from the date of disability established by your doctor. Otherwise, your Loss of Time Benefits will begin on the eighth (8^{th}) consecutive day after you first receive medical attention.

2. Termination of Loss Of Time Benefits

If you are injured or ill, your Loss of Time Benefits will end on the earlier of:

a) The date you receive your 20 or 26 weeks of payments, depending on the Plan; or
b) The date your Employer no longer makes timely contributions to the Plan on your behalf; or
c) The date your doctor states you can return to work.

If you are pregnant, your Loss of Time Benefits will end on the later of:

a) The date you receive your six (6) weeks of payments every twelve (12) month period; or
b) The date your Employer no longer makes timely contributions to the Plan on your behalf; or
c) The date your doctor states you can return to work if you have been under the continuing care of a doctor due to complications related to the pregnancy. However, your Loss of Time Benefits will never extend beyond 20 or 26 weeks of payments, depending on the Plan.

If you are Disabled due to Mental Health or substance abuse reasons, your Loss of Time benefits will end on the earlier of:

a) The date you receive your four (4) weeks of payments every twelve (12) month period; or

b) The date your Employer no longer makes timely contributions to the Plan on your behalf; or
c) The date your doctor states you can return to work.

If you decide to retire while receiving Loss of Time Benefits, your payments will end on your Retirement Date, even if you have not received the maximum amount of payments. If you designate a Retirement Date that falls within the period during which you have received Loss of Time Benefits, you will be asked to refund all payments made to you for the period following your Retirement Date.

Loss of Time Disability Benefits will not be paid for illnesses or injuries that are work-related, covered by Worker's Compensation or an Occupational Disease Law.

3. Re-Establishing Loss Of Time Benefits

If your Loss of Time Disability Benefits ends, you can begin a new period of Loss of Time Disability Benefits under either of the following situations (as long as you remained covered under the Plan while you were Disabled and unable to work):

a) A Related Disability: If your second disability is related to your first disability, you must work for four (4) consecutive weeks before you can qualify for Loss of Time Benefits again.

   For example: John, a Participant, had ulcers and received 5 weeks of Loss of Time Benefits. John returned to work and after 15 days on the job, his ulcers flared up and he was disabled again. Can John begin a new Loss of Time period? No. John could not begin a new Loss of Time period because he had not worked 4 consecutive weeks. He could, however, collect benefits for the 21 weeks out of the 26 weeks he had not claimed earlier.

b) An Unrelated Disability: If your second disability is not related to your first disability, and if at least one (1) day of work for which a contribution is required on your behalf separates your claims for disability benefits, you will begin a new period of Loss of Time Benefits.

   For example: Betty, a Participant, received 12 weeks of Loss of Time Benefits for an illness. Betty went back to work. Two days after she returned to work she was in a car accident and broke her leg. Can Betty begin a new Loss of Time Benefits period? Yes. She returned to work for at least one day and the second claim was unrelated to the first. She is eligible to collect the maximum of 20 or 26 weeks Loss of Time Benefits, depending on her Plan.

c) An Unrelated Disability during the Same Period of Loss of Time Benefits: If your second disability is not related to your first disability, and arises before elimination of the first disability and during the same period of Loss of Time Benefits as the first disability, you will be eligible to continue the same period of Loss of Time benefits.

   For example: Betty, a Participant, was receiving Loss of Time Benefits for an illness. During this Loss of Time Benefits period, Betty suffered a second, but unrelated, disability due to injury. If Betty's illness-related disability resolves, but her disability due to her injury continues, can she continue her Loss of Time Benefits period? Yes. Betty can continue the existing Loss of Time Benefits period because of her disabling injury, without returning to work. Can she qualify for a new Loss of Time Benefits period? No. Unless Betty goes back to work, she cannot qualify for a new Loss of Time Benefits period.

C. MEDICAL BENEFITS

You, your Spouse and Dependents may have medical benefits in the areas listed below. Follow the Plan's specific guidelines for receiving care to ensure maximum coverage, and refer to your At-a-Glance Schedules of Benefits for the applicable Deductibles, Co-insurance or/and Co-payments and applicable Calendar Year Benefit Maximum. Each area below explains what benefits are available for specific treatments, items or services, and may also describe some items and services for which coverage is not available. You will be responsible for translation fees that are necessary for services performed, and the cost of services performed, outside of the United States. Please refer to the Exclusions and Limitations under Section VI for additional information regarding services outside of the U.S.

For convenience and ease of reference, many of the Benefit Sections below list specific exclusions for each benefit; however, Section VI herein provides a more comprehensive list of the treatments, procedures, services and devices that the Plan does not cover.

1. Allergy Injections

In the Active and Retiree Plans, allergy injections are paid at the rate specified on your At-a-Glance Schedule of Benefits, subject to your Deductible and Co-insurance.

2. Ambulance

The Plan covers professional, licensed land or air ambulance transportation charges provided to obtain essential medical attention as determined by the Fund (i.e., accidental Injury, Medical Emergency, or transfer between facilities). The Fund may require transportation by a commercial carrier when determined in the Fund's sole judgment to be medically appropriate and more cost-effective than a private ambulance service.

What Is Not Covered includes but is not limited to:

a) Transportation in any privately owned vehicle;
b) Services and supplies for which you are not legally required to pay;
c) Transportation for reasons other than obtaining essential medical treatment;
d) Ambulance charges should you call for an ambulance and then refuse transportation for care; and
e) Transportation to receive medical treatment, which is also available at a location where other treatment is currently being provided.

3. Appliances, Prostheses and Durable Medical Equipment

The Plan will cover prosthetic devices, appliances and either the rental or purchase (the lesser amount) of durable medical equipment for home use. To qualify for coverage, appliances, prostheses and durable medical equipment must be:

a) Prescribed by a physician before their rental or purchase;
b) Medically Necessary;
c) Primarily and customarily used only for medical purposes;
d) Designed for prolonged use; and
e) Serve a specific therapeutic purpose in the treatment of an illness or Injury.

Appliances, prostheses and durable medical equipment may include, but are not limited to:

a) Surgical implants;

b) Terminal devices such as artificial limbs, hands or hooks;
c) Prosthetic lenses;
d) Obturators to fill palate cavities;
e) Foot orthotics;
f) Orthopedic shoes (prescription required);
g) Wheelchairs (except motorized or electric);
h) Walkers;
i) Crutches;
j) Traction equipment;
k) Oxygen or oxygen supplies;
l) Canes; and
m) Glucometers (can be purchased at the Fund Pharmacy).

What Is Not Covered includes but is not limited to:

a) Durable medical equipment (other than oxygen or oxygen supplies) is not covered under the Retiree Plans;
b) Replacement of an appliance, whether it is lost, stolen or otherwise missing, more often than once every five (5) years, except foot orthotics which may be replaced once every two (2) years and orthopedic shoes which may be replaced once every calendar year;
c) Rental or purchase of durable medical equipment over $1,000 which has not been pre-approved by the Fund. (Remember that all rentals or purchases of durable medical equipment over $1,000 must be pre-approved.); and
d) Durable medical equipment for Seasonal Affective Disorder, such as "Bright Light" and similar products.

4. Chiropractic Care

The Plan covers chiropractic care services if they are necessitated by illness or Injury and performed by or under the direction of a legally qualified or licensed chiropractor. All services performed or prescribed by a chiropractor including x-rays, laboratory, therapy, office visits and any other covered services will be processed solely under this benefit.

What Is Not Covered includes but is not limited to:

Maintenance Care is excluded from the Chiropractic Care Benefit for all Plans.

5. Diagnostic/Therapeutic X-ray, Laboratory and Technical Procedures – Outpatient

Outpatient diagnostic and technical services performed at a Hospital, a physician's office, or the Wisconsin Health Fund clinic are covered as long as the underlying illness is not work-related. Covered procedures also include:

a) CT scans;
b) Magnetic Resonance Imaging (MRI);
c) Electroencephalograms (EEG);
d) Electrocardiograms (ECG or EKG); and
e) Other procedures that the Fund determines are Medically Necessary and/or appropriate.

What Is Not Covered includes but is not limited to:

a) Body scans, unless deemed appropriate in the sole discretion of the Fund for certain conditions and illnesses;
b) Handling fees; and
c) Heart scans.

6. Emergency Care

The Plan will only cover emergency services that the Fund determines are Medically Necessary and appropriate.

The Fund defines a Medical Emergency as a traumatic Injury or medical condition which, if not immediately treated, might cause complications, jeopardize full recovery or cause permanent damage (or in the case of pregnancy, threaten the health of the mother or her unborn child). A heart attack, stroke, poisoning, loss of consciousness, an incident involving severe bleeding or convulsions are considered to be examples of "medical emergencies." Similar conditions may also be determined by the Fund to be medical emergencies, in the Trustees' sole discretion.

If you have a life-threatening Medical Emergency, you should obtain care at the nearest urgent care center or Hospital emergency room. The Medical Emergency must be reported to the Fund's Medical Management Department within 48 hours if you are admitted through an Emergency Room. In order to maximize your benefits and reduce your out-of-pocket costs, follow-up care should be obtained at the Wisconsin Health Fund Medical and Dental Centers or from another in-network provider.

A network physician may be able to treat the condition at an unscheduled office visit or may determine that an urgent care center or Hospital emergency room visit is necessary.

> Example: Sam feels sharp chest pain and can't breathe. His wife takes him straight to the emergency room at the local hospital where he is diagnosed and treated for a heart attack. The emergency services are covered because Sam had a life-threatening emergency. Sam's wife did not have to call first for Pre-Authorization because a heart attack is a life-threatening emergency, but she does have to report the emergency care to the Fund within 48 hours to ensure coverage and obtain instructions for Sam's follow-up care.

> Example: Sara cut her hand while making dinner. Her husband Jeff wasn't sure if she should go to the emergency room or to her physician's office. Jeff called the physician's office, and was instructed to bring Sara to the office for care.

7. Hearing Aids

The Plan will consider up to $1,000 per ear for approved conventional hearing aids, fittings and the first set of batteries. Benefits are subject to applicable Deductible and Co-insurance. The hearing aid benefit is available once every thirty-six (36) months. All services must be:

a) Provided by an audiologist or certified hearing aid specialist; and/or
b) Recommended or prescribed by a physician who issues a prescription.

What Is Not Covered includes but is not limited to:

a) Replacement of lost, missing or stolen hearing aids;
b) Repair or replacement of broken hearing aids;
c) Replacement of batteries; and
d) Retirees do not have a Hearing Aid benefit.

8. Home Health Care

The Plan will pay for sixty (60) visits/Calendar Year for intermittent skilled care performed by a registered nurse (RN), licensed practical nurse (LPN), physical therapist or occupational therapist, or any combination thereof, if all the following conditions are met:

a) You must be homebound;
b) The home treatment must be skilled and medically appropriate;
c) The treating physician must order the home treatment; and
d) The home treatment must be authorized by the Medical Management Department by calling the appropriate number listed on your Wisconsin Health Fund medical identification card.

What Is Not Covered includes but is not limited to:

a) Custodial Care;
b) Private duty care;
c) Services that the Medical Management Department deems not Medically Necessary or appropriate; and
d) Unskilled care.

9. Inpatient Hospital and Hospice Care

Covered charges include Medically Necessary and/or appropriate services such as:

a) A semi-private room and board;
b) General nursing care; and
c) Charges for an eligible newborn.

Inpatient Hospital and hospice stays must be authorized by the Medical Management Department by calling the appropriate number listed on your Wisconsin Health Fund medical identification card.

With the exception of any charges that the Plan limits or excludes, covered charges include the following services when Medically Necessary and appropriate:

a) Diagnostic and therapeutic radiology;
b) Pathology;
c) Technical procedures (such as CT scans, MRI, etc.);
d) Anesthesia;
e) Medicine while an Inpatient (take-home medications are not covered);
f) Medical supplies; and
g) Other services that the Fund deems Medically Necessary and/or appropriate.

Unless private accommodations are Medically Necessary and appropriate, Covered Persons are responsible for the difference in room rates between the most common semi-private and private accommodations.

What Is Not Covered includes but is not limited to:

a) Personal comfort items or services including, but not limited to, telephones, televisions, admission kits, magazines, hair appointments, and any other personal care items or services;
b) Take home medications; and
c) Services that the Medical Management Department deems not Medically Necessary or appropriate.

10. Inpatient Rehabilitation

The Plan allows thirty (30) days per Calendar Year total for any combination of care provided in a state licensed Inpatient rehabilitation facility if the following conditions are met:

a) The patient must be able to tolerate and the facility must supply three (3) hours of combined skilled rehabilitation services each and every day the patient is present in the facility; and
b) All Inpatient rehabilitation stays must be pre-authorized by the Medical Management Department by calling the appropriate number listed on your Wisconsin Health Fund medical identification card.

Examples of facilities/programs that would be covered under this benefit include state licensed acute Inpatient rehabilitation facilities; state licensed brain Injury or coma recovery type programs.

What Is Not Covered includes but is not limited to:

a) Bed hold charges or charges of any kind for periods during which the patient is away from the facility or on a home pass when that period extends beyond twelve (12) hours;
b) Services not pre-authorized or which are deemed not Medically Necessary or appropriate by the Medical Management Department; and
c) Services in non-state licensed facilities or non-state licensed programs.

11. Skilled Nursing/Extended Care Facilities

The Plan covers thirty (30) days per Calendar Year total for any combination of care provided in a state licensed skilled nursing or extended care facility when care is Medically Necessary and appropriate such as:

a) Semi-private room and board;
b) General nursing care; and
c) Medically Necessary and appropriate skilled therapy.

The Inpatient stay in a skilled nursing/extended care facility must be pre-authorized by the Medical Management Department by calling the appropriate number listed on your Wisconsin Health Fund medical identification card.

Types of facilities covered under this benefit include state licensed Long Term Acute Care facilities, Sub-Acute facilities, Skilled Nursing Facilities that provide skilled nursing/therapy services.

What Is Not Covered includes but is not limited to:

a) Assisted living facilities;
b) Personal care facilities;
c) Custodial Care;
d) Bed hold charges or charges of any kind for periods during which the patient is away from the facility or on a home pass when that period extends beyond twelve (12) hours; and
e) Non-state licensed facilities.

12. Maternity Benefits

Maternity benefits include prenatal, delivery and postnatal services such as:

a) Hospitalization;
b) Caesarean section; and
c) Technical procedures (such as ultrasound, fetal monitoring, etc.)

The Plan pays the same portion of covered maternity services as it pays for any medical care. In other words, whatever portion of Inpatient Hospital care the Plan covers for an Injury is the amount the Plan covers for Inpatient Hospital care for the delivery of a child.

Maternity stays must be pre-certified through the Medical Management Department by calling the appropriate number listed on your Wisconsin Health Fund medical identification card.

13. Organ Transplants/Transplants

You must contact the Medical Management Department at **414-771-5600** or **1-800-680-6840** before receiving any transplant services. Failure to do so will result in a denial of benefits. For coverage to exist, you must also use a Designated Transplant Center, identified by the Fund. The Fund may also require that two (2) Board Certified Specialists confirm, in writing, the need for an organ transplant prior to any surgery.

The Plan covers the following transplants, in the amount your particular Plan allows (all the usual Co-pays, Co-insurance, Deductibles, maximums, etc. apply):

a) Heart;
b) Heart/Lung;
c) Kidney;
d) Liver;
e) Bone Marrow; and
f) Others as approved by the Fund.

Transplant Benefit Coverage includes:

a) Pre-transplant evaluation;
b) Pre-transplant harvesting;
c) Pre-transplant stabilization (that is, an Inpatient stay necessary to prepare the patient for transplantation);
d) The transplant itself;
e) Twelve (12) months of follow-up care, post transplant at a Designated Transplant Center;
f) Organ procurement and recovery costs; and
g) Medications at the Designated Transplant Center and a 30-day take-home supply of prescription medication.

Donor Benefits

The expenses incurred by a live donor are covered as if they were your expenses, provided:

a) You received the transplant; and
b) The Plan covered the transplant.

Reimbursement For Travel Expenses

The Fund also recognizes that traveling to a Designated Transplant Center may involve transportation, lodging and meal expenses. The Plan will reimburse, up to a maximum of $10,000, the actual amount of the following expenses:

a) Transportation for the patient and one immediate family member; and
b) Lodging and meals up to a maximum of $125 per day for both the patient and one (1) immediate family member.

All transportation, lodging and meal costs are treated as Covered Expenses. You must provide the Fund with all receipts in order for the expenses to be considered for reimbursement.

Second Opinion Policy. If you are denied a transplant procedure by the Designated Transplant Center, the Medical Management Department will make a referral to a second Designated Transplant Center for evaluation. If the second facility determines, for any reason, that you are an unacceptable candidate for a transplant procedure, no coverage will be provided for further transplant-related services and supplies, regardless of a third Designated or non-Designated Transplant Center's acceptance.

What Is Not Covered includes but is not limited to:
The Plan will not cover organ transplant charges related to any of the following:

a) Charges which exceed reasonable and customary charges as determined by the Fund;
b) Animal to human transplants;
c) Artificial or mechanical devices designed to replace human organs;
d) Any treatment or care required to keep a donor alive for transplant operation;
e) Services not incurred at a Designated Transplant Center;
f) Transplant related services prior to the effective date of coverage;
g) Transplants that are considered not Medically Necessary or appropriate by the Fund;
h) Any other limitations or exclusions specified by this Booklet;
i) Travel expenses incurred at a non-Designated Transplant Center; and
j) Transplants for or through the coverage of Fund Retirees

14. Physical and Rehabilitation Therapy Services

The Plan will cover physical and rehabilitation therapy services, including respiratory therapy. For physical therapy services provided outside the Wisconsin Health Fund Medical Center, the Plan will cover up to 30 visits of physical therapy services per Calendar Year, depending on your level of coverage under the Plan, and any additional visits must be reviewed for Medical Necessity. For physical therapy services provided at the Wisconsin Health Fund Medical Center, no Calendar Year Benefit Maximum shall apply.

What Is Not Covered includes but is not limited to:

a) Occupational therapy (other than for an upper extremity or due to a cerebrovascular accident (stroke) or brain injury);
b) Therapy for work-related injuries or illness;
c) Speech therapy, unless medically appropriate and necessary due to cleft palate, laryngectomy or post-cerebral vascular accident;
d) Physical therapy and rehabilitation therapy performed by persons other than licensed physical therapists, for work-related or occupational cases, or for any work-hardening or similar plans;
e) Physical therapy in excess of 30 visits per Calendar Year; and
f) Any therapy designed to assist with the activities of daily living (other than for the upper extremities or in cases of strokes or brain injuries)

15. Radiation Therapy

The Plan will cover the use of x-rays, radium cobalt and other radioactive substances unless otherwise specified herein.

16. Surgical Benefits

Upon prior authorization by the Fund, the Fund will pay benefits shown in the schedule of benefits, for the Usual and Customary Charge (as determined by the Fund) incurred for Medically Necessary and appropriate Inpatient or Outpatient surgery (as determined by the Fund). Two or more procedures performed during the course of a single operation through the same incision or in the same operative field will be considered as one procedure. The Fund will pay benefits for the Usual and Customary Charge (as determined by the Fund) for the major procedure.

If there are multiple surgical procedures in separate operative fields and separate incisions, the Fund will pay benefits at 100% of the Usual and Customary Charge (as determined by the Fund) for the major procedure, and 50% of the Usual and Customary Charge (as determined by the Fund) for the second (and any such additional) procedure(s).

The Usual and Customary Charge may include physician's care following the surgical procedure. Other procedures performed at the same time as the primary procedure but not essential for completion of the primary procedure will not be considered for reimbursement. If an assistant surgeon is Medically Necessary, the Fund will pay benefits for Usual and Customary Charges not to exceed 20% of the allowable amount for the surgical procedure.

17. Smoking Cessation

The Plan will cover:

a) Screening for tobacco use; and
b) For those who use tobacco products, no restrictions on tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    1) Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    2) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. Coverage does not apply to brands where an equivalent generic is available.

18. Preventive Health Services

When delivered by an in-network provider, the Plan will cover preventive health services for adults, women and children at no cost to you, to the extent required by the Affordable Care Act (i.e., the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)).

D. Mental Health and Alcohol/Substance Abuse Treatment Benefit

All Mental Health and substance abuse treatment services are subject to a managed care program, and must be pre-authorized by the Plan's Mental Health and substance abuse treatment benefit administrator (the "**MHSAT Administrator**") prior to any such services being rendered. This means that the

MHSAT Administrator must decide that your care is Medically Necessary before you will be eligible for the payment of benefits.

Obtaining Care
To coordinate Inpatient and Outpatient services, Covered Persons should contact the MHSAT Administrator using the contact information provided by Wisconsin Health Fund. Covered Persons must contact the MHSAT Administrator prior to obtaining any Inpatient or Outpatient care in order to receive full benefits relating to drug abuse or dependency; alcohol abuse or dependency or Mental Health care.

If you would like the names of in-network providers, you can call toll free 1-888-208-8808. The MHSAT Administrator customer service representatives can give you the names, specialties, addresses, phone numbers, and professional qualifications of in-network providers.

Emergency Care
In an Emergency, you should seek care immediately from the closest provider/facility, or call 911, the local police or fire department for help. You should call the MHSAT Administrator as soon as possible after seeking Emergency care. If you are admitted to a facility, you (or someone acting on your behalf) must call the MHSAT Administrator within 72 hours of your admission.

Urgent Care
You should call your health care professional immediately in a non-Emergency (but urgent) situation. You (or someone acting on your behalf) must call the MHSAT Administrator within 24 hours of the first business day after receiving urgent care.

Non-Emergency Inpatient Care
You (or someone acting on your behalf) must call the MHSAT Administrator before you are admitted to a facility for non-Emergency care. After receiving the necessary clinical information, the MHSAT Administrator will authorize your admission if the MHSAT Administrator determines that it is Medically Necessary and otherwise covered under the Plan.

Transitional Care
If your health care professional decides you should receive Transitional Care, you must follow the rules listed above for non-Emergency Inpatient care admissions. Transitional Care may be substituted, at the MHSAT Administrator's discretion, for Inpatient services for the treatment of nervous and mental conditions, or drug and alcohol abuse or addiction. In the event that Transitional Care is substituted for Inpatient services, one (1) day(s) of Transitional Care shall be equivalent of one (1) day(s) of Inpatient services. However, the substitution of Transitional Care for Inpatient services shall in no way increase the total benefit days or visits available.

Continued Inpatient Stay
The MHSAT Administrator will contact the facility and/or your health care professional regularly during your Inpatient care to monitor your progress, help with discharge planning, and determine the Medical Necessity of ongoing care.

Outpatient Care
You must call the MHSAT Administrator before you start Outpatient care for behavioral health problems or your benefits will be reduced. Also, you must call the MHSAT Administrator each time

you are going to see a different provider and each time you start a new episode of care. The MHSAT Administrator will send a treatment plan form to your provider. This form requests information on your condition and planned treatment. Your provider will complete this form and ask you to sign it. By signing the form, you are agreeing to participate in your treatment and are giving your provider permission to release your medical information to the MHSAT Administrator.

The MHSAT Administrator will review the treatment plan your provider submits and will authorize the Medically Necessary number, frequency, and type of outpatient visits. The MHSAT Administrator will send a copy of the reviewed treatment plan to your provider which will list the number of authorized visits with the start and end dates of the authorization. The MHSAT Administrator will also send you a letter with the same information. If you see your provider for more than the number of visits authorized by the MHSAT Administrator, or after the end date of your authorization, the MHSAT Administrator will not authorize those visits.

If you stop your Outpatient care for 60 or more days and want to restart it, you (or someone acting on your behalf) must call the MHSAT Administrator before you begin your treatment again in order to be eligible for full benefits.

Pre-Certification and Authorization For Different Providers
You must call the MHSAT Administrator before treatment each time you plan to receive behavioral health care from a different provider.

Example 1: You are seeing a provider for medication management and you are also attending a partial hospitalization program. You must call the MHSAT Administrator for authorization for both the medication management and partial hospitalization program.

Example 2: You call the MHSAT Administrator and are referred to a therapist. During this episode of care, the therapist refers you to another provider. You must call the MHSAT Administrator about the second provider to receive benefits for the care from the second provider.

Second Opinions
A second opinion of a provider's recommended treatment or diagnosis for behavioral health problems is covered if the second opinion is provided by a provider chosen by the MHSAT Administrator. Additional testing or treatment you receive in connection with the performance of a second opinion will not be covered unless it is specifically authorized by the MHSAT Administrator.

Telephone Numbers For Pre-Certification and Authorization
Contact the MHSAT Administrator using the contact information provided by Wisconsin Health Fund or call Wisconsin Health Fund at 1-888-208-8808.

Court-Ordered Services
The MHSAT Administrator covers Medically Necessary Inpatient, Outpatient and Transitional Care you receive as a result of an Emergency detention, involuntary commitment or court order to the extent benefits would have been available had any required referral been made and the services performed by a provider chosen by the MHSAT Administrator. If services are provided by an in-network provider or facility or a referral provider or facility, benefits are subject to the limitations stated in this Plan for Inpatient, Outpatient and Transitional Care. If services are provided by an out-of-network provider or facility or a non-referral provider, benefits shall be subject to the limitations for Inpatient, Outpatient

and Transitional Care stated in this Plan and the following two (2) conditions: 1) The services could not have been provided by a provider or facility chosen by the MHSAT Administrator, and 2) you, the provider or facility, or a person acting on your behalf notifies the MHSAT Administrator within seventy-two (72) hours of the initial provision of services.

When the MHSAT Administrator is notified that you are receiving services, the MHSAT Administrator will arrange for further Medically Necessary services to be provided by an in-network provider or facility or a referral provider or facility. Out-of-network providers and facilities and non-referral providers will only be paid the maximum payment under the state medical assistance program for the services they provide.

Covered Providers and Facilities
You must receive care from a provider or facility that meets one of the following requirements to be eligible for payment for benefits:

a) Has a master's degree, is certified or licensed to provide clinical services for behavioral health and/or chemical abuse/dependence by the state in which services are being provided, AND is providing services through a licensed outpatient facility, or
b) Has a PhD in psychology (psychologist) and is licensed to provide clinical services by the state in which services are being performed, or
c) Is a physician (MD, DO) who is licensed and legally entitled to practice medicine, is practicing within the scope of his/her license, has completed a residency in psychiatry, and whose primary practice is to treat behavioral health problems, or
d) Is a program provided by and at an outpatient treatment facility or clinic. The program and the facility must be approved, established, and maintained according to the applicable state authority (this includes individual providers who are licensed or certified by the applicable state authority), or
e) Is a facility that: 1) Holds a license as a hospital (if licensing is required in the state); 2) is accredited by The Joint Commission and/or is a hospital or psychiatric hospital qualified to participate and eligible to receive payments under and in accordance with Medicare, 3) provides organized facilities for diagnosis and treatment either on its premises or at an institute with which it has a formal arrangement for the provision of such facilities, and 4) maintains an organized specialty psychiatric unit or operates as a psychiatric specialty facility.

Benefit Table

Inpatient Care and Transitional Care	**Percentage Payable Subject to Authorization**	
	In-Network	**Out-of-Network**
	Plan Y-20 = 90% Plan Y-85 = 80%	Plan Y-20 = 60% Plan Y-85 = 50%
Outpatient Care	**Percentage Payable Subject to Authorization**	
	In-Network	**Out-of-Network**
	Plan Y-20 = 90% Plan Y-85 = 80%	Plan Y-20 = 60% Plan Y-85 = 50%

Failure to Contact the MHSAT Administrator Prior To Receiving Treatment
If you do not contact the MHSAT Administrator before receiving any Inpatient or Outpatient care for the services listed above, or do not follow the advice of the MHSAT Administrator-contracted

professional, your benefits may be reduced or eliminated. If you contact the MHSAT Administrator and follow the advice and recommendations provided by the MHSAT Administrator, your normal benefits will not be reduced.

What Is Not Covered includes but is not limited to:

a) Psychological testing, unless necessitated by certain illnesses; and
b) Services pertaining to marriage counseling and/or sex therapy.

E. PRESCRIPTION DRUG BENEFIT

For all Plans, prescriptions must be filled at a Fund-approved pharmacy. The Fund has its own pharmacy adjacent to the Wisconsin Health Fund clinic. Over-the-counter medications and any prescription medications that contain the same active ingredient(s) at the same strength as an existing over-the-counter medication are not covered under the Plan.

1. Determining Payment

Maximum benefits are most often available when you fill prescriptions at the Fund Pharmacy, located at 6118 West Bluemound Road, Milwaukee, WI, 53213. The amount you pay for a prescription drug depends on whether you receive a generic or a brand name drug. Whether it is a brand name or generic drug, you pay the Co-insurance level (a percentage of the actual cost), but not less than the minimum Co-payment or Usual and Customary Charge, unless the actual cost of the drug is less than the minimum Co-payment. Please see below for additional prescription drug benefit information.

a) Availability of Specialty Drugs
    1) All fills of prescriptions for specialty drugs are limited to the Fund Pharmacy and the Fund's preferred specialty mail order pharmacy (or pharmacies);
    2) First fills of prescriptions for specialty drugs are limited to fifteen (15) day supplies; and
    3) Additional fills of prescriptions for specialty drugs are limited to thirty (30) day supplies.
b) Removal of Dispense as Written Requirement
    1) Generic equivalents of prescription drugs must be used, if available;
    2) Fund participants may elect to purchase branded prescription drugs, so long as they pay the difference between the generic equivalent and the applicable branded prescription drug; and
    3) In the event a branded prescription drug is medically necessary, no reduction in prescription drug benefits will apply.
c) Application of Prescription Drug Step Therapy
    1) First step is use of preferred generic equivalents of prescription drugs, if available;
    2) Second step is use of non-preferred generic equivalents of prescription drugs, if available;
    3) Third step is use of preferred branded prescription drugs, if available; and
    4) Fourth step is use of non-preferred branded prescription drugs, if available.

2. Replacement of Prescription

You must pay the full cost of replacing the prescription if the pharmacy benefit was used on the original prescription. The attending physician must authorize a refill.

3. Mail Order Prescription Service

The mail-order program is primarily for maintenance or non-Emergency Prescriptions. You can obtain mail order prescriptions through the Fund Pharmacy at 6118 West Bluemound Road, Milwaukee, WI, 53213. To dispense a prescription, the Fund Pharmacy must have a prescription for you on file. The first prescription may be mailed or delivered to them, or you may have remaining refills transferred by phone between pharmacies. The prescription may be renewed until the number of refills or time runs out. After that, a new prescription must be presented.

Because shortages may arise, you should request refill prescriptions two weeks in advance of when you will need them. Applicable Co-pays apply. You may request information about Mail-Order prescriptions through the Fund's Customer Service Department at 1-888-208-8808. Maximum benefits available are most often obtained when you fill mail-order prescriptions at the Fund Pharmacy, as illustrated by your At-a-Glance Schedules of Benefits.

4. Emergency Prescriptions

If you need an Emergency Prescription and cannot use a Fund-approved pharmacy, the Plan will pay for a ten (10) day supply filled at any pharmacy. You will have to pay for the prescription at the pharmacy. The Plan will reimburse you for all amounts the Fund approves, less the normal Co-insurance.

A form for reimbursement of Emergency Prescriptions is available from the Fund's Customer Service Department or from the Fund Pharmacy. Before you can be reimbursed, this form must be filled out and submitted along with the following:

a. A paid receipt showing that the prescription was for you, your Spouse or a Dependent;
b. The name of the drug and quantity;
c. The daily dosage;
d. The prescription number;
e. The name of the physician; and
f. The pharmacy license number.

The Plan will only reimburse you. It will not pay the pharmacy. If you have additional questions regarding the prescription drugs available, or the benefits available for certain prescription drugs, you may contact the Fund.

F. DENTAL BENEFITS

Depending on your type of coverage under the Plan, you, your Spouse and Dependent children may have dental benefits. Your dental benefits can be obtained, up to the calendar year maximum, from any dental provider, and you may also use the Wisconsin Health Fund Dental Center. Enhanced Benefits may apply if you use the Wisconsin Health Fund Dental Center. Although it is not required, the Fund recommends using a network provider to reduce your costs and paperwork. There is no penalty for using an out-of-network dental care provider, but enhanced benefits are only available at the Wisconsin Health Fund Dental Center.

Dental Benefits are not offered in the Retiree Plans. Retirees, however, may receive dental care at the Fund's Dental Center, and this care may be provided at a discounted rate to Retirees.

1. Covered Dental Services

Below is a listing of examples of services covered in each category. Additional rules applying to dental procedures may be listed under "Additional Limitations and Exclusions Applicable to Dental Benefits or the Medical Benefits sections.

Preventative and diagnostic services include but are not limited to:

a) X-rays;
b) Examinations;
c) Cleaning of teeth (prophylaxis only);
d) Sealants (through age 14); and
e) Fluoride (through age 14).

Basic restorative procedures include but are not limited to:

a) Gross debridement (4355) and periodontal maintenance (4910);
b) Amalgam restorations;
c) Composite restorations;
d) Stainless steel crowns;
e) Space maintenance appliances (through age 12); and
f) Non-surgical extractions.

Major Restorative Procedures include but are not limited to:

a) Fixed prosthetics - crowns, bridges, inlays and onlays;
b) Removable prosthetics - dentures and partials;
c) Root canals;
d) Periodontal therapy exclusive of prophylaxis and gross debridement and surgery;
e) Fixed restoration benefit (note that to allow patients to pursue cosmetic options in dentistry, the Fund will pay up to the maximum benefit for a full cast high noble crown, allowing the patient to opt to apply this toward the cost of comparable fixed restorations); and
f) Removable restoration benefit (note that to allow patients to pursue alternatives to partials and dentures, the Fund will pay up to the maximum benefit for full dentures allowing the patient to opt to apply this toward the cost of comparable immediate prosthetics or implant retained removable prosthetics).

Medical Classified Procedures

a) Surgical extractions;
b) Periodontal surgery;
c) Outpatient hospital and general anesthesia for dental work on children age 4 and under (note that services for children age 5 and over require Pre-Authorization) and
d) IV sedation and nitrous oxide when done in conjunction with medical procedure or when Medically Necessary.

Service Dates Used for Claim Payments: Services associated with Fixed Prosthesis (crowns, bridges, inlays and onlays) or with Removable Prosthesis (dentures and partial dentures) will be deemed to be performed after the prosthesis is initially cemented or inserted. Services associated with root canal therapy will be deemed to have been performed when the canals of the tooth have been obturated (filled). If your dental coverage ends, claims for any dental services performed before the termination will be unaffected. A benefit will be paid for single services irreversibly started within thirty (30) days prior to termination and completed within thirty (30) days after termination.

Fixed Restoration Benefit: To allow you to pursue options in dentistry, WHF will pay up to the maximum benefit for a full cast high noble crown on posterior teeth, thus allowing you to apply this toward the costs of porcelain to metal crowns and bridges, porcelain ceramic crowns and bridges or implant retained crowns and bridges.

Removable Restoration Benefit: To allow you to pursue alternatives to dentures, WHF will pay up to the maximum benefit for full dentures, thus allowing you to opt to apply this toward the cost of immediate dentures or implant retained dentures

Implants may be covered on a case-by-case basis, but are limited to two specific situations at the sole discretion of the Fund:

1. Two mandibular implants for a lower implant retained denture, if;
    a. One mandibular denture must have been tried prior to approval; and
    b. Documentation must prove that a standard denture cannot be worn and that implants will substantially increase the likelihood of the successful use of a denture.
2. Up to two implants to replace single missing maxillary incisors, so long as the surrounding teeth are sound and natural.

2. Dental Pre-Authorizations

Your dentist must submit your treatment plan to the Fund for Pre-Authorization if your dental treatment plan is anticipated to cost more than $500.00. In addition, you must pre-authorize any treatment for, or which is related to, Temporomandibular Joint Syndrome, or any upper and lower jawbone surgery, as many of these procedures are not covered under the Plan. Dental Pre-Authorizations are valid for 30 days from the date they are issued by the Fund.

3. Orthodontic Care

Your At-a-Glance Schedule of Benefits will specify whether the Plan provides Orthodontic benefits (coverage is provided in all Premier Plans). The Fund will cover orthodontic care for Dependent children up to the age of 19, with a lifetime maximum of $1,000.00. Orthodontic services must be rendered by a Dentist or an Orthodontist, and are covered when they are to correct one or more of the following dental problems:

a) The existence of extreme bucco-lingual version of the teeth, either unilateral or bilateral;
b) A protrusion of the maxillary teeth of 4 or more millimeters;
c) An open bite of 4 or more millimeters;
d) A protrusive or retrusive relation of the maxillary or mandibular arch of at least 1 cusp, and/or
e) An arch-length discrepancy of 4 or more millimeters.

What Is Not Covered includes but is not limited to:

a) Orthodontic services rendered past the Dependent child(ren)'s 19th birthday;
b) Any charges in excess of $1,000.00;
c) Any orthodontic services that do not meet the above criteria;
d) Expenses for incomplete procedures or appliances that are not inserted and/or related services; and
e) Any charges for surgical procedures to correct malocclusion with exceptions as listed in Section VI.B. entitled "Additional Limitations and Exclusions Applicable to Dental Benefits."

G. VISION BENEFITS

Depending on your type of coverage under the Plan, you, your Spouse and Dependent children may have vision benefits. Covered vision care can be obtained from either a Fund-approved vision center, or from any other vision provider. However, Covered Persons can maximize their benefits, and lower their out-of-pocket expenses, by receiving care from Fund-approved vision centers. If you receive vision care from a non-Fund-approved vision provider, the Fund may pay an amount which is less than the Fund would have paid if you had visited a Fund-approved vision center. Additional information on available vision benefits can be found on your At-a-Glance Schedule of Benefits. By maximizing benefits at Fund-approved vision centers, the Fund encourages (but does not require) Covered Persons to seek vision care through Fund-approved vision centers.

1. Contacts Instead of Glasses

The Fund will pay vision benefits for contact lenses, in lieu of glasses, up to the maximum benefit for bifocals, as shown on your At-A-Glance Schedule of Benefits. In other words, the Plan will cover either glasses or contact lenses during a Calendar Year. This means that if you choose contacts, the Plan will not cover glasses for you during that Calendar Year.

VI. WHAT THE PLAN DOES NOT COVER

For convenience and ease of reference, many of the Benefit Sections in this Booklet listed specific exclusions for each benefit. However, this Section provides a more comprehensive list of the treatments, procedures, services and devices that the Plan does not cover. This section also outlines Worker's Compensation and Suspension of Benefits.

For a complete listing of Plan exclusions and limitations, please refer to the Plan Document.

A. EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to **all benefit Plans**, except Life and Accidental Death and Dismemberment. The Plan will not pay any expenses or any benefits incurred in connection with:

1. Accident, Injury or Sickness arising out of or in the course of any occupation or work for compensation, wage or profit, or benefit which may be payable under Worker's Compensation Law, Occupational Disease Law or similar law, whether or not application for Worker's Compensation benefits has been made. However, if for whatever reason the Fund does expend benefits, then the Participant and or Dependent shall fully pursue and prosecute a Worker's Compensation claim and the terms and conditions of Section X. Subrogation/Reimbursement of this Booklet shall apply;
2. Services other than those certified by a legally qualified physician, surgeon, dentist, optometrist, ophthalmologist, chiropractor, physician's assistant, nurse practitioner or other health care professionals;
3. Disability, Accident or Sickness caused by any act of war;
4. Self-inflicted injuries and/or illnesses caused by intent to harm oneself, except when the action taken resulted from a physical or mental condition;
5. Prescription drugs, unless filled at a Fund-approved pharmacy or Emergency Prescriptions filled in accordance with the emergency pharmacy benefit;
6. Take-home drugs upon discharge from a Hospital, except for Emergency Prescriptions filled at the Hospital upon discharge;
7. Any Hospital or medical service furnished by or at the expense of a Hospital or facility operated by the U.S. Government or any authorized agency of the U.S. Government for an Injury or illness resulting from military service or caused by an act of war;
8. Abortions (other than therapeutic);
9. Orthodontic services, except where otherwise allowed;
10. Correction of malocclusion;
11. Treatment for, or that which is related to, Temporomandibular Joint Syndrome or any upper and lower jawbone surgery in excess of $5,000 per lifetime, except for treatment related to an appropriate diagnosis, in the Fund's sole judgment, of acute traumatic Injury or cleft palate. Any exceptions to this exclusion must be preauthorized prior to receiving services;
12. Charges or expenses incurred prior to the effective date of eligibility or coverage;
13. Charges or expenses incurred after the termination date or eligibility or coverage, except prosthetic devices which were fitted and ordered prior to termination of coverage and which were delivered within thirty (30) days after the date of termination of coverage;
14. Replacement of an appliance, whether it is broken, lost, stolen or otherwise missing, more often than once every five (5) years, except foot orthotics, which may be replaced once every two (2) years;
15. Supplying or fitting of hearing aids for Retirees;

16. Private duty nurse or visiting nurse in a Hospital;
17. Cosmetic Surgery and conditions arising from Cosmetic Surgery (unless resulting from Accident and determined in the Fund's sole judgment to be restorative, in which case coverage is for a maximum period of one (1) year from date of Accident providing the individual remains otherwise eligible, or breast reconstructive surgery following covered mastectomy under the Plan);
18. Speech therapy, unless determined to be Medically Necessary and appropriate in the Fund's sole judgment due to cleft palate, laryngectomy or post-cerebral vascular accident;
19. Physical therapy and rehabilitation therapy performed by persons other than licensed physical therapists, for work-related or occupational cases, or for any work hardening or similar plans or programs;
20. Physical therapy in excess of 30 visits per Calendar Year, except as approved and Pre-Authorized by the Fund;
21. Any therapy designed to assist with the activities of daily living (other than for the upper extremities or in cases of strokes or brain injuries);
22. Occupational therapy;
23. Charges related to self-donation of blood or blood plasma;
24. Psychological testing, unless necessitated by certain illnesses;
25. Rental or purchases of certain wheelchairs, hospital beds or other durable medical equipment, unless Medically Necessary and appropriate in the Fund's sole judgment;
26. Health services, drugs and associated expenses for infertility services, including, but not limited to, invitro-fertilization, gamete intra fallopian transfer and embryo transport, surrogate parenting, donor semen and artificial insemination;
27. Genetic testing, genetic counseling and drugs related to both, except as required by applicable law;
28. Surgical procedures for obesity, weight-related problems or removal of fat tissue, including gastric stapling and gastric bypass, intestinal bypass, liposuction, lipectomy or any other surgical procedure performed to remove fat tissue
29. Over-the-counter medications and any prescription medications for obesity, weight-related problems or removal of fat tissue;
30. Purchase of support hose or stockings, slings or ace bandages;
31. Use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as acceptable medical practice; or that is in the Fund's sole judgment to be Experimental or Unproven in nature; or not approved by the FDA. The fact that an Experimental or Unproven treatment, procedure, facility, equipment, drug, device or supply is the only treatment, procedure, facility, equipment, drug, device or supply available for a particular condition will not result in Plan coverage if the treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or Unproven in the treatment of that particular condition;
32. Supplies and equipment for the use of oxygen in the home, except as approved by the Fund;
33. Syringes and hypodermic needles unless used for the administration of insulin or other diabetic medication;
34. Services, treatments, supplies or charges which are not Medically Necessary and appropriate, in the Fund's sole judgment, for the medical treatment to maintain or improve health;
35. Treatment for injuries caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance;

36. For care primarily for rest, convalescence, case findings, research, educational purposes or for Custodial Care;
37. Personal comfort items or services including, but not limited to, telephones, televisions, admission kits, magazines, hair appointments, and any other personal care items or services;
38. Contraceptives, except prescription contraceptives such as oral birth control pills, injectables (e.g., Depo-Provera), Intrauterine devices (IUDs), diaphragms, female condoms and implantable birth control devices and services (e.g., Norplant);
39. Reversal of elective, surgically-induced sterility including, but not limited to, the reversal of vasectomies and tubal ligations;
40. Cosmetic Surgery and other cosmetic procedures, services, treatments, supplies, and charges related to gender dysphoria or sex transformation, and conditions arising from Cosmetic Surgery and such other cosmetic procedures, services, treatments, supplies, and charges;
41. Devices and disposables including hairpieces, wigs, chucks, diapers, rubber sheets, disposables that could be purchased in a pharmacy without a prescription and disposables which are necessary for personal hygiene or maintenance of a medical condition, such as dressings, tape, bandages and alcohol, unless determined Medically Necessary and appropriate in the Fund's sole judgment;
42. Acupuncture services;
43. Examination or testing for employment, purchase of insurance or pre-marital purposes;
44. Services pertaining to marriage counseling and/or sex therapy;
45. Services provided by an immediate Family Member or by a person who normally lives in your home;
46. Chiropractic care that is determined in the Fund's sole judgment to be Maintenance Care;
47. Any balance over the usual and customary charge determined or established in the Fund's sole judgment;
48. Over-the-counter medications and any prescription medications that contain the same active ingredient(s) at the same strength as an existing over-the-counter medication;
49. Services, treatments, supplies or charges related to complications resulting from any treatment, services or supplies which are otherwise excluded under this Booklet;
50. Services, treatments, supplies or charges for or related to sclerotherapy;
51. Services, treatments, supplies or charges related or provided pursuant to a prescription five (5) years old or older;
52. Nutritional supplements and infant formula;
53. Services, treatments, supplies or charges for or related to non-emergency care received outside the United States;
54. Travel for health, whether or not recommended by a physician, except where otherwise allowed;
55. Charges incurred outside the United States if you traveled to such location for the purpose of obtaining medical services, drugs or supplies;
56. Biofeedback;
57. Batteries;
58. Digital Breast Tomosynthesis (3-D Mammography), except when such screening mammograms are mandated by law and/or as part of standard medical practice;
59. Services, treatments, supplies or charges related to or provided in the home, except Home Health Care; and
60. Any and all other exclusions listed herein this Booklet.

B. ADDITIONAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT BENEFITS

The following additional exclusions and limitations apply to Mental Health and substance abuse treatment services provided in connection with following conditions:

1. All dementia, including dementia of the Alzheimer's type, vascular dementia, alcohol-induced persisting dementia, other or unspecified psychoactive substance dementia, and dementia NOS;
2. Treatment for smoking cessation, except as specifically described in this Booklet as a covered medical benefit; and;
3. Psychiatric or psychological examinations, testing, or treatments for purposes of obtaining or maintaining employment, or insurance, or relating to judicial or administrative procedures, including services rendered pursuant to a condition of parole or probation;
4. Any services or supplies for any injury, defect, illness, or disease arising out of or in the course of employment for wage or profit or for which you are entitled to benefits under any Worker's Compensation or occupational disease act or law;
5. Any services or supplies for which you have no legal obligation to pay and/or for which no charge would be made in the absence of your coverage under the Plan;
6. Any charges for completion of insurance or benefit claim forms or for failure to keep a scheduled visit with a physician or other treating provider;
7. Any physical or psychological examination requested or required by a third party such as school, sports, or camp examination;
8. Treatment, services, and supplies which are Experimental;
9. Any services which are not rendered face-to-face;
10. Any charges incurred for facility services for those days you are on leave from the facility, but have not been discharged;
11. Any charges incurred at a rest home, nursing home, home for the aged, school for the mentally retarded, or other institution for services which are primarily educational or custodial care rather than primarily curative in function;
12. Any charges incurred for treatment, services, or devices that are primarily items of convenience for your comfort rather than primarily curative in function (examples of this are dietary substitutions, travel (such as vacations or moving to dry climates), and other such devices or treatment);
13. Psychotropic and all other medications (including vitamins);
14. Court ordered services that are deemed assessments, treatment or confinement for certain conditions unless this treatment is determined to be Medically Necessary. These conditions include, but are not limited to:
    a) Marital problems;
    b) Parent/child problems;
    c) Phase of life problems;
    d) Occupational problems;
    e) Adult antisocial behavior;
    f) Academic problems (childhood or adolescent antisocial behavior);
    g) Assessment for operating motor vehicle while intoxicated; and
    h) Sex offenders; and
15. Medically Necessary services which are received pursuant to an emergency detention under the Mental Health Act, or a commitment or court order under the Mental Health Act or

guardianship proceedings will be covered to the extent the services are benefits under this Plan or would be covered with an authorized referral;
16. Quality of life enhancements (examples include, but are not limited to, parent training and assertiveness training);
17. Services or supplies obtained by any person through the fraudulent use of a Participant's or a Dependent's identification card, as benefits under this Plan may not be transferred to any other person or party;
18. State tax on goods or services;
19. Services or supplies rendered by a provider who is a member of your immediate family. Immediate family means your spouse, children, parents, grandparents, and brothers/sisters and their spouses;
20. Psychoanalysis;
21. Pain management;
22. Sleep disorders;
23. Vocational counseling;
24. Problems of life that are not a Mental Health illness and/or substance abuse disorder;
25. Methadone maintenance;
26. Psychosurgery;
27. The following impairments if they are the primary focus of treatment: Mental retardation, learning disorders, motor skill disorders, communication disorders, pervasive developmental disorders;
28. Alcohol-induced persisting amnestic disorder and other or unspecified psychoactive substance amnestic disorder;
29. Amnestic disorder (etiology noted on Axis III or is unknown);
30. Autistic disorder;
31. Factitious disorder with psychological or physical symptoms;
32. Factitious disorder NOS;
33. Insomnia related to another mental disorder (nonorganic), primary insomnia, hyperinsomnia related to another mental disorder (nonorganic), circadian rhythm sleep disorder, sleep terror disorder, sleepwalking disorder, dyssomnia NOS, nightmare disorder, parasomnia NOS;
34. Pain disorder associated with psychological factors;
35. Frontal lobe syndrome; and
36. Organic brain syndrome;

Benefits may exist for certain services provided in connection with the conditions described above if such services are expressly covered under this Plan.

C. Additional Limitations and Exclusions Applicable to Dental Benefits

The following <u>additional</u> exclusions and limitations apply to all Dental Benefit Plans. The Plan will not pay any expenses incurred in connection with:

1. Charges for failure to keep scheduled appointments;
2. Any uncompleted procedure;
3. Appliances other than prosthodontic appliances;
4. Oral hygiene and dietary instruction;
5. Plaque control programs;
6. Re-evaluations;
7. Case presentations;

8. Oral exams, prophylaxis, periodontal maintenance, fluoride treatment or bitewing x-rays more than twice per Calendar Year;
9. Gross debridement and root planning more than once every five (5) years;
10. Full mouth or panoramic x-rays more than once every three (3) years except when due to trauma or cancerous pathology;
11. Orthodontic services, except where otherwise allowed;
12. Correction of malocclusion;
13. Cosmetic dentistry (e.g., porcelain veneers, bleaching of teeth, and crowns or restorations for aesthetic reasons);
14. Crowns and/or bridgework without sufficient bone support or supported by implants;
15. Permanent crowns and/or bridgework on deciduous (baby) teeth, except in the absence of the applicable adult tooth;
16. Any maxillary anterior crown done without proof of dental pathology by means of radiographs or photos as determined by the Fund's sole discretion;
17. Temporary crowns, unless determined Medically Necessary and appropriate in the sole judgment of the Fund;
18. Sealants on teeth other than the 1st and 2nd molars;
19. Replacement of any fixed prosthetic restoration with another fixed restoration more than once every five (5) years (this includes but is not limited to crowns, bridges, inlays, onlays and stainless steel crowns);
20. Replacement of any removable prosthetic restoration with another removable restoration more than once every five (5) years (this includes but is not limited to dentures and partial dentures);
21. Replacement of any fixed or removable prosthesis for cosmetic reasons (e.g., chipped porcelain);
22. Denture or partial denture reline within six (6) months after initial insertion and no more than once every three (3) years thereafter;
23. Interim dentures;
24. Implants including, but not limited to, endodontic, subperiosteal, transosteal, and osseointergrated implants not specifically covered in the Plan;
25. Removal of implants not specifically covered in the Plan;
26. Fixed or removable prosthetic work placed on implants not specifically covered in the Plan;
27. Replacement of any lost or stolen appliance;
28. Restorations, appliances or services to replace lost tooth structure due to attrition or decreased vertical dimension;
29. Any procedure that becomes necessary due to treatment excluded by the Plan;
30. Occlusal adjustments;
31. Diagnostic casts;
32. Appliances made for prevention of harmful habits;
33. Night guards and splints; and
34. Any and all other exclusions listed herein this Booklet.

D. Additional Limitations and Exclusions Applicable to Vision Benefits

The following <u>additional</u> exclusions apply to all Vision Benefit plans. The Plan will not pay any expenses incurred in connection with:

1. More than one (1) complete examination every Calendar Year;

2. More than one (1) pair of lenses every Calendar Year, unless determined Medically Necessary and appropriate in the sole judgment of the Fund;
3. More than one (1) set of frames in a Calendar Year;
4. Any non-prescription lenses or other luxury items in the sole judgment of the Fund;
5. Any loss or expense incurred for, or resulting from:
   a. Procedures or supplies furnished on account of a visual defect, which arises out of, or in the course of, any occupation for wage or profit;
   b. Any medical or surgical treatment of the eye as an vision benefit; and
   c. Orthoptics, vision training or aniseikonia;
6. Any laser or refractive surgery, including Radial Keratotomy ("RK"); and
7. Any and all other exclusions listed herein this Booklet.

E. WORKER'S COMPENSATION

The Plan covers illnesses and injuries that are not work-related. Your benefits do not replace Worker's Compensation Benefits. Worker's Compensation is a state fund to which your employer contributes and which pays for work-related injuries or illnesses. It is very important for you to know what kind of protection Worker's Compensation provides.

State Worker's Compensation laws vary from state to state. You should know about the law in your state. To find out, you may contact the applicable State Bureau of Worker's Compensation or a local office. In Wisconsin, contact the Wisconsin Department of Workforce Development, Worker's Compensation Division. It is the responsibility of the staff who administer Worker's Compensations programs to see that your claim is handled quickly and efficiently.

It is important to note that if you have a work related injury, you must not wait to file a claim under Worker's Compensation. There are often time limits on how long you can take to file a claim, and if you miss the time limit, you may not be able to file at all. Here are some suggestions to help you get the benefits that may belong to you:

1. Let your employer know when you are injured or think that you are ill because of conditions on the job;
2. See a doctor immediately, preferably one who has taken Worker's Compensation cases and knows your industry;
3. Get in touch with your local union representative who will help you contact the right offices and people; and
4. Contact your state Worker's Compensation office or a local office to get your claim started.

You may also wish to contact a Worker's Compensation lawyer to see that your claim is filed and handled properly.

You may choose to receive care through the Wisconsin Health Fund Medical and Dental Centers, or any other health care provider, for a Worker's Compensation injury or illness.

F. SUSPENSION OF BENEFITS

Your eligibility for coverage under the Plan is based upon contributions made on your behalf each month by your employer. If your employer continuously fails to make the contributions required by the Fund on your behalf, your benefits may be suspended. Before your benefits are suspended, however, you will receive a written notice advising you that your benefits are about to stop.

Following the suspension period, if your employer makes the contributions that were owed, all claims that would have been paid, if your coverage had not been suspended, will be paid by the Plan on your behalf or on behalf of your Spouse or Dependent children, as applicable.

VII. RETIREE BENEFIT PLAN

This section describes the benefits available through the Fund's Retiree Plans. Retiree Coverage is not provided by all Plans or for all retirees. Participants should refer to their Collective Bargaining Agreement or their Employer's Participation Agreement or call the Fund to determine if they are eligible to receive Retiree Benefits.

A. ELIGIBILITY REQUIREMENTS

The Retiree Benefit Plan is a special Plan of benefits for retirees, their Spouses and Dependent children. You must meet certain requirements to qualify for Retiree Plan coverage. These requirements are explained below. No Participant, Retiree or any other Covered Person has a "vested" right to any benefits provided under the Plan. The Plan Trustees have the discretion to change the amount, manner, form and duration of any benefit provided herein and to increase, decrease or eliminate any benefit provided herein.

The Retiree Benefit Plan comes in two different forms: The R1 Plan and the R2 Plan, and Participants should refer to their At-a-Glance Schedules of Benefits for details. You must select either the R1 Plan or the R2 Plan at the time you begin receiving benefits. Once you make your selection, you are not allowed to change it. However, your Spouse may select either the R1 Plan or the R2 Plan at the time you reach 65 or become eligible for Medicare.

Important: Please note that if you become eligible under the Plan for the first time on or after January 1, 2018, you cannot qualify and are not eligible for Retiree Plan coverage.

1. Establishment and Maintenance of Retiree Benefits

At the time of your request for Retiree benefits, the following requirements must be met in order for you to qualify for Retiree Coverage:

a) You must be eligible under the Plan at the time of retirement or termination of employment from a WHF participating employer which is or was also participating in the Retiree Benefit Plan; and
b) Your retirement or termination of employment must be from an employer who has been making contributions on your behalf or COBRA continuation; and
c) Your Request for Qualification must be made within thirty (30) days of termination from a contributing employer or COBRA continuation; and
d) In the event you are gainfully employed, you must provide proof that you are not eligible for health and welfare benefits from your employer; and
e) You must have obtained the applicable amount of years of service (see below).

Keep in mind that in order to qualify for retiree benefits, you must meet the requirements stated in a), b), c) and d) above, and also meet the applicable amount of years of service described in the following table.

In addition, the following requirements must be met in order to maintain eligibility for the Retiree Plans:

a) You must pay the applicable monthly premium for Retiree Benefit Plan benefits in a timely manner; or
b) If you choose to defer your benefits, you must provide proof that you have other insurance (see "Deferment of Right to Retiree Benefits" below).

The term "year" or "years" as used in this section, including the following table, means forty (40) weeks of full-time work in a Calendar Year or the "vesting service years" as defined in the Pension Contribution and Status Summary applicable to you.

All Retiree Plans
Age 57 and older Contributions for 5 out of the last 5 years or a total of 7 years within the last 10 AND 20 years of service in a Fund represented industry.
Age 52 to 56 Contributions for 10 out of the last 10 years or a total of 10 years with at least 7 in the last 10 AND 25 years of service in a Fund represented industry.
Age 51 or less Contributions for 15 out of the last 15 years or a total of 15 years with at least 7 in the last 10 AND 30 years of service in a Fund represented industry.

2. Retiree Benefit Plan Coverage Premium

A monthly premium for Retiree Benefit Plan Coverage is required. To receive Retiree benefits, you must pay the applicable monthly premium in a timely manner.

3. Deferment of Right to Retiree Benefits

If you meet the qualifications for Retiree Benefit Plan coverage, you may defer your right to your benefits, in lieu of other insurance. If you wish to reinstate your benefits, you must contact the Fund within thirty (30) days of the other insurance's termination and provide proof of termination of the other insurance. Any waiver due to other coverage must be continuous, with no break in such coverage.

4. Termination of Retiree Coverage

Your coverage under the Retiree Benefit Plan ends on the **earliest** of the following dates:

a) The first of the month you first become eligible for Medicare benefits due to age;
b) The date you first become eligible for Medicare benefits;
c) The date you die;
d) The date your applicable monthly premium is more than thirty (30) days late; or
e) The date you become eligible for group health coverage due to re-employment or through your spouse's employer.

Your Retiree coverage will also terminate when your contributing employer fails to make contributions to the Plan for any reason, including but not limited to when your contributing employer: (1) bargains out of the Plan and replaces the Plan with other health care coverage; or (2) bargains out of the Plan and fails to provide any health care coverage in its Collective Bargaining Agreement; or (3) prior to January 1, 2018, discontinues the retiree component of its weekly or monthly premium contribution to the Plan.

After a contributing employer's contributions cease for any reason, the affected Retiree may continue retiree coverage upon the terms and conditions described herein if the Retiree makes timely, continuous non-subsidized self-payments in weekly or monthly installments, as directed by the Fund, at the then-current full cost of the Plan retiree coverage which can and may be adjusted by the Plan Trustees from time to time as circumstances warrant.

B. SPOUSE ELIGIBILITY SUMMARY

1. Establishment of Spousal Coverage Under the Retiree Benefit Plan

Generally, your Spouse becomes covered under the Retiree Benefit Plan when your coverage starts. If you get married after your coverage starts, your Spouse's coverage will begin on the date you marry. You must notify the Fund regarding your Spouse within thirty (30) days of the date of your marriage. If the Fund does **not** receive a completed enrollment change form within thirty (30) days of the marriage, the change will not be considered until the next annual open enrollment. Your Spouse's eligibility will not be established until you submit proof of insurability that is acceptable to the Fund.

2. Termination of Spousal Coverage Under the Retiree Benefit Plan

Your Spouse's coverage under the Retiree Benefit Plan, except as explained below, will end on the **earliest** of the following:

a) The first of the month in which your Spouse first becomes eligible for Medicare benefits due to age;
b) The first of the month in which your 65th birthday falls;
c) The date of your Spouse's death;
d) The date your Spouse becomes eligible for Medicare;
e) The date you become eligible for Medicare;
f) The last day of the month in which you die;
g) The date on which your Spouse is no longer married to you; or
h) The date your applicable monthly premium is more than thirty (30) days late.

3. Extended Retiree Benefit Plan Coverage for Your Spouse

Your Spouse may be eligible for extended Retiree Benefit Plan coverage if your Spouse is under age 65 and not eligible for Medicare or any other health benefits when you reach 65 or become eligible for Medicare. The extended coverage will remain effective as long as the monthly premium is paid and will continue until the **earliest** of the following:

a) The first of the month in which you first become eligible for Medicare benefits due to age;
b) Your Spouse's Medicare eligibility date;
c) The date of your Spouse's death;
d) Three (3) years beyond your 65th birthday;
e) Three (3) years beyond the last day of the month in which you die; or
f) Three (3) years beyond the date on which your Spouse is no longer married to you.

Your Spouse may select either the R1 Plan or the R2 Plan at the time you reach 65 or become eligible for Medicare.

4. Spousal Coverage Upon Becoming Medicare Eligible

Your eligibility for Medicare will not adversely affect the eligibility of your Spouse for Extended Retiree Benefit Plan coverage under the Fund.

5. Your Spouse's Reinstatement of Deferred Retiree Benefits

As described above, if you meet the qualifications for Retiree Plan coverage, you may defer your right to your benefits, in lieu of other insurance. If you die before reinstating benefits, your Spouse may reinstate benefits on behalf of the deceased Participant. Your widow or widower must contact the Fund within thirty (30) days of your death in order to reinstate benefits. However, in no event will your Spouse's eligibility for extended Retiree Benefit Plan coverage continue for more than three (3) years from the date your Spouse originally became eligible for extended Retiree Benefit Plan coverage or extend beyond the termination of coverage dates described in Section VII.B.2 above.

C. DEPENDENT CHILDREN ELIGIBILITY SUMMARY

Refer to the eligibility requirements described in Section II.D. entitled Dependent Children Eligibility Summary.

1. Establishment of Dependent Child Coverage Under the Retiree Benefit Plan

Generally, your Dependent child will start coverage in the Plan at the same time you do. If you have a child while covered under the Plan, coverage for the child will start at birth. You must notify the Fund within thirty (30) days of the birth, adoption, or the date you become legally obligated to provide coverage for the child, as applicable. If the Fund does **not** receive a completed enrollment change form within thirty (30) days of the events described herein this paragraph, the change will not be considered until the next annual open enrollment. Your Dependent's eligibility will not be established until you submit proof of insurability that is acceptable to the Fund.

2. Termination of Dependent Child Coverage Under the Retiree Benefit Plan

Your Dependent child's coverage under the Retiree Benefit Plan, except as explained below, will end on the earliest of the following:

a) The first of the month in which you first become eligible for Medicare benefits due to age;
b) The date of your Dependent child's death;
c) The date your Dependent child becomes eligible for Medicare;
d) The date you become eligible for Medicare;
e) The date on which your Dependent child ceases to be a Dependent child; or
f) The date your applicable monthly premium is more than thirty (30) days late.

3. Extended Retiree Benefit Plan Coverage for Your Dependent Child

Your Dependent child may be eligible for extended Retiree Benefit Plan coverage if your Dependent child is not eligible for Medicare or any other health benefits when you reach 65 or become eligible for Medicare. The extended coverage will remain effective as long as the monthly premium is paid and will continue until the earlier of the following:

a) Your Dependent child's Medicare eligibility date; or
b) Three (3) years beyond the first of the month you first became eligible for Medicare benefits due to age.

Your Dependent child may select either the R1 Plan or the R2 Plan at the time you reach 65 or become eligible for Medicare.

4. Dependent Coverage Upon The Participant Becoming Medicare Eligible

Your eligibility for Medicare will not adversely affect the eligibility of your Dependent child for Extended Retiree Benefit Plan coverage under the Fund.

5. Your Dependent's Reinstatement of Deferred Retiree Benefits

As described above, if you meet the qualifications for Retiree Plan coverage, you may defer your right to your benefits, in lieu of other insurance. If you die before reinstating benefits, your Dependent may reinstate benefits on behalf of the deceased Participant. Your Dependent must contact the Fund within thirty (30) days of your death in order to reinstate benefits. However, in no event will your Dependent's eligibility for extended Retiree Benefit Plan coverage continue for more than three (3) years from the date your Dependent originally became eligible for extended Retiree Benefit Plan coverage or extend beyond the termination of coverage dates described in Section VII.C.2 above.

D. Medical and Pharmacy Benefits Only

Retiree Plan Participants are eligible for **Medical and Pharmacy benefits only**. No other benefits are available to Retiree Plan Participants. Retiree Plan Participants may choose their own health care providers, however, better benefits are received through the Fund's network of Preferred Providers and maximum benefits are received though the Wisconsin Health Fund Medical Center (refer to your At-a-Glance Schedule of Benefits for details). There is a financial penalty (e.g., through reduced benefits) for services received outside the network or not pre-authorized by the Plan.

1. Benefits Included In The Retiree Plans

a) Physician office visits, including visits to the Wisconsin Health Fund Medical Center;
b) Hospital Emergency Room visits;
c) Inpatient Hospital care;
d) Outpatient Hospital diagnostic and technical services;
e) Skilled nursing/extended care facility;
f) Outpatient and Inpatient Mental Health and substance abuse treatment;
g) Allergy Injections;
h) Chiropractic Care;
i) Physical and Rehabilitation Services;
j) Appliances and Prostheses;
k) Radiation Therapy;
l) Home Health Care;
m) Prescription Drugs; and
n) Hospice Care.

Refer to Section V. entitled "Covered Benefits" and the At-a-Glance Schedules of Benefits for specifics (e.g., coverage, Co-pays, Deductibles, out-of-pocket and Calendar Year Benefit Maximums) and exclusions applicable to each of these benefits.

E. What Your Retiree Medical Benefits Do Not Cover

1. Exclusions and Limitations

a) Durable medical equipment (except oxygen);
b) Supplying or fitting of hearing aids;
c) Occupational and speech therapy;
d) Life insurance and accidental death and dismemberment;
e) Dental services;
f) Loss of Time benefits;
g) Transplants;

h) Optical/vision services; and
i) Oral surgery pertaining to teeth and/or gums.

Additional exclusions are described in Section VI of this Booklet entitled “What The Plan Does Not Cover.”

VIII. CLAIMS

A. FILING A CLAIM FOR BENEFITS

You should always file a claim as soon as possible. Claims will not be reviewed for payment later than one (1) year from the date the charges were incurred.

1. Initial Claim

You can submit an itemized written claim form (including your Social Security number or your WHF subscriber ID number) with the Benefit Department, or can have the treating physician or other provider file the claim at the appropriate address listed on your Wisconsin Health Fund medical identification card. Do not send the Fund your "balance due" statements. Claims should be filed as soon as possible after receiving treatment. Your claim may be denied if it is not received by Wisconsin Health Fund within 90 days of the date of service (the date of service is the day the service or supply is actually provided). If you receive additional bills which are not your financial responsibility, you should contact Wisconsin Health Fund customer service at 1-888-208-8808.

You can also submit an itemized written claim form for Mental Health/Substance Abuse services to either Health Management Center or Optum Behavioral Health at the following respective addresses:

Health Management Center
PO Box 981605
El Paso, TX 79998

Optum Behavioral Health
PO Box 30555
Salt Lake City, UT 84130

2. Times for Processing Claims

The benefits provided by the Plan will be paid to the provider or to you after the Plan receives satisfactory written proof of the services provided. In the case of loss of life or total incapacity of the claimant, the Plan may, at its option, make payment for services provided to you and/or your Dependent to any one or more of the following: a provider of services, or you and/or your Dependent Spouse or estate. Any good faith payment made by the Plan under this provision will fully discharge the Plan for that payment.

In most cases, the Fund will issue a decision on an initial claim no later than:

a) 72 hours for urgent care claims;
b) 15 days for pre-service claims;
c) 30 days for post-service claims;
d) 24 hours for urgent care requests for an extension of approved benefits; or
e) 45 days for disability benefit claims (the Fund may choose to extend the time period twice, up to a maximum of 105 days total).

If reasonably necessary, the Fund may take an additional 15 days to decide pre- and post-service claims.

3. Explanation of Benefits

You will be provided with an explanation of what has and has not been paid on your claim. The Fund will determine benefit payment amounts by either a fixed schedule that specifies maximum amounts allowable for a particular treatment or the percentage of the applicable and appropriate charge.

4. Claim Denial

The most common reasons for a claim denied in full, or in part, are:

a) You, your Spouse or your Dependent children were not covered by the Plan when a service was performed;
b) The service performed was not covered by the Plan;
c) The charge for a service exceeded the Usual and Customary Charge allowed by the Plan; and
d) The claim was submitted later than one year from the date the charges were incurred.

If you have any questions concerning your claim payments, you should call the Fund at 1-888-208-8808. If you disagree with the handling or resolution of your claim, you may appeal the claim determination through an Appeal Process which is explained below. Information relied upon to determine your claim is available at no charge to you upon request from the Fund.

B. CLAIM PAYMENTS

1. False Claims

If you purposely makes a false statement to receive benefits, your claim will be rejected and the Fund will be entitled to recover any payments made on your behalf.

2. Overpayments

The Fund has and reserves the right to recover any overpayment of benefits made on any claim you file or that is filed on your behalf. If the Fund has difficulty in recovering an overpayment, the amount of the overpayments will be deducted from future claims you file or that are filed on your behalf. In addition, the Fund may file appropriate collection and other legal actions in order to recover any such overpayments.

3. Change of Address

If you move, you must notify the Fund of the new address. To request a Change of Address form or submit your information by phone, Covered Persons can contact the Fund at:

Wisconsin Health Fund
6200 West Bluemound Road
Milwaukee, WI 53213
1-888-208-8808

If the Fund is unable to contact you by mail because of a change of address, the Fund will hold any of your benefit payments, without interest, until you provide the new address.

4. Claim Determinations Policies and Procedures

a) The Fund will not impose fees or costs as a condition to filing or appealing a claim.
b) If your treating physician determines that a claim is “urgent,” the Fund will treat it as “urgent.”
c) All appeals will be reviewed without giving deference to the prior decision-maker’s decision or findings.

d) The Internal Review Committee (see below, C. The Appeal Process) will have no involvement in the initial claim determination.
e) The Board of Trustees (see below, C. The Appeal Process) will have no involvement in the initial or Internal Review Committee's decisions.
f) The Internal Review Committee and the Board of Trustees will consider the opinions of appropriate health care professionals in deciding appealed claims involving medical judgment.
g) If you are receiving approved care over a period of time, you may obtain Internal Review Committee or Board of Trustees review before such benefits are reduced or terminated; however, requests for such review must be made within two weeks of receiving notification that the benefits will be reduced or terminated.
h) The Fund will notify you, within five (5) days for non-urgent claims, and within 24 hours for urgent pre-service claims, if such claims fail to follow the Fund's claims procedures, or fail to provide the necessary information needed to process the claims.
i) Claim determinations will include specific reasons for denials, including identification and/or free access to, copies of any guidelines, rules, protocols, or similar criterion, relied upon in making any adverse determinations.
j) All documents, records and other information relevant to a claim decision shall be made available for your review upon written request to the Fund's Benefit Department.
k) The Fund shall disclose, upon request, the names of any medical professionals consulted as part of the claims determination process.

C. The Appeals Process

1. If You Disagree With The Payment Of Your Claim

If your claim is denied or only partially paid, and you disagree with its settlement, you may ask to have it reviewed. The Fund has established a two-step process for appealing a claim determination. This process is intended to give you the opportunity for two independent reviews of your claim, if necessary. In order to receive a review at each Appeal Level, you must carefully follow the process explained here.

2. Level 1 – Internal Review Committee (For Claims other than Mental Health and Substance Abuse Treatment Services)

If you are notified that your claim (for services other than Mental Health and substance abuse treatment services) has been denied or only partially paid and you disagree with the decision, you may have the Internal Review Committee review your claim. To initiate this level of review, you must send a written request for review to:

WHF Internal Review Committee
6200 West Bluemound Road
Milwaukee, WI 53213

The Internal Review Committee must receive the written request for review within one-hundred eighty (180) days of the initial claim decision. Your request for review must contain all of the following information:

a) Your name, address and Social Security number or WHF subscriber ID number ;
b) The name, address and Social Security number or WHF subscriber ID number of the Covered Person, if different from you;
c) The Covered Person's relationship to you (husband, wife, son, daughter, etc.), if applicable;
d) Claim number, if known;
e) The date of loss for which the claim was made; and

f) A statement explaining why you believe the handling of the claim was wrong.

The Internal Review Committee will issue a decision on an appeal of a denied claim no later than:

a) Seventy-two (72) hours for urgent care claims.
b) Fifteen (15) days for pre-service claims.
c) Thirty (30) days for post-service claims.

There will be a delay in these time frames if your request for review did not contain all the required information.

The notice that the Internal Review Committee sends you will contain the following information:

If The Covered Person's Claim Is Again Denied Or Only Partially Paid:

a) The exact reason why your claim was again denied or only partially paid.
b) A reference to the Section of the Booklet on which the denial was based.
c) An explanation of the process for the next step of review.

If Additional Information Is Required:

a) A listing of additional information needed, if any, that might help approve your claim.
b) An explanation of why additional information may be necessary.

3. Level 1 – Special Review (For Claims for Mental Health and Substance Abuse Treatment Services)

If you are notified that your claim for Mental Health and substance abuse treatment services has been denied or only partially paid and you disagree with the decision, you may have the MHSAT Administrator Special Reviews Department review your claim. To initiate this level of review, you may send a written request to the MHSAT Administrator using the contact information provided by Wisconsin Health Fund (or you may call Wisconsin Health Fund at 1-888-208-8808 for such information).

The MHSAT Administrator Special Reviews Department must receive the written request for review within one-hundred eighty (180) days of the initial claim decision. Your written request for review should include the following:

a) Your name, address and Social Security number or WHF subscriber ID number ;
b) The name, address and Social Security number or WHF subscriber ID number of the Covered Person, if different from you;
c) The date and place of service;
d) The provider's name;
e) The amount of the claim(s) and the claim number(s); and
f) A statement explaining why you believe the handling of the claim was wrong.

The MHSAT Administrator will acknowledge your request for review in writing within 5 business days of receiving it. The MHSAT Administrator will review all relevant facts, including any materials or records you submit. You or your authorized representative may appear before the MHSAT Administrator Grievance Committee to present more written or oral information, or question the people who made the decision about which you filed the request for review. The MHSAT Administrator will inform you of the meeting time and place at least 7 days in advance. The MHSAT Administrator will report the final decision to you in writing upon the earlier of: (1) a reasonable amount of time appropriate to the medical circumstances; (2) 30 days of receiving your request for review. If there are special circumstances that require more time, the MHSAT Administrator may take 60 days to review

your case before making its decision. The MHSAT Administrator will inform you if extra days are needed.

If you need urgent care, you may file your request for review by telephone. You should give the MHSAT Administrator the information listed above. The MHSAT Administrator will process your request for review as expeditiously as your health condition requires, but no later than within 72 hours of your call. The MHSAT Administrator will orally report the final decision to you upon the earlier of: (1) As soon as possible taking into account the medical exigencies; or (2) within 72 hours. The MHSAT Administrator will also report the final decision to you in writing within 3 calendar days of the oral notification.

4. Level 2 – Board of Trustees

If you are still dissatisfied with the claim determination, the decision of the Internal Review Committee may be appealed to the Fund's Board of Trustees. To have the Board of Trustees review the claim, you must submit a written request for review to:

WHF Board of Trustees
6200 West Bluemound Road
Milwaukee, WI 53213

You are also entitled to submit additional written issues and comments to the Board of Trustees at this time. Your appeal to the Board of Trustees must be submitted within thirty (30) days after you received your Level 1 Internal Review Committee decision.

Unless further information is required, the Board of Trustees will review your claim at their next regular meeting, and you may expect to receive their decision as soon thereafter as reasonably possible. If your claim is denied, the Board of Trustee's notice of decision to you will contain:

a) The exact reason your claim was denied, (including reference to any internal protocols relied upon, if any); and
b) A reference to the Section of the Booklet on which the refusal was based.

If your claim is denied, you are entitled, upon request, to review any documents that were created or received by the Fund during the appeals process at no cost to you.

If your appeal concerns an adverse benefit determination that is based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary or appropriate, the Board of Trustees will consult with an independent health care professional. The independent health care professional will have appropriate training and experience in the field of medicine related to the medical judgment. The independent health care professional will not be the same person with whom the Internal Review Committee consulted in the initial adverse benefit determination or the subordinate of such person.

5. 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:

- clinical reasons;
- exclusion for Experimental services;

- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- 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 processes identified above and you receive a decision that is unfavorable, or if the Fund fails to respond to your appeal in accordance with applicable regulations.
If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Fund will have an opportunity to meet with the independent reviewer or otherwise participate in the independent reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You 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 under the Plan. The Fund has contracted with The Independent Review Organizations ("**IRO**") which have no material affiliation or interest with the Fund. The Fund will choose the IRO based on a rotating list of appropriately accredited 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 the Fund's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by the Fund in making a decision on the case; and
- all other information or evidence that you or your physician has already submitted to the Fund.

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 the Fund 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 the Fund 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 Fund 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 Fund will not be obligated to provide benefits for the service or procedure.

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

6. Access to Courts

If, after you have followed the Appeal Process through both Level 1 and Level 2, you are still dissatisfied with the resolution of your claim and believe that the claim denial was arbitrary and capricious, you have the right to take your claim denial to court. However, you cannot bring any action in law or equity to recover under the Plan more than 3 years after the date of the initial claim decision that is the subject of the action.

IX. COORDINATION OF BENEFITS

*If you have coverage under more than one group plan (for example, your Spouse's group plan), the Fund will coordinate with your Other Plan. If you, your Spouse or any of your Dependent children sustain an injury in a motor vehicle accident and there is no-fault or Personal Injury Protection ("**PIP**") Motor Vehicle Insurance Coverage, the Fund will coordinate benefits with that insurance coverage. Coordination of Benefits provides complete payment of your allowable expenses while preventing duplicate payment(s) for the same service. Coordination of Benefits does not apply to your Life Insurance Benefit nor does it apply when you or your Dependent children have individual health policies.*

A. GENERAL COORDINATION OF BENEFITS INFORMATION

Coordination of Benefits takes place when you, your Spouse or your Dependent children are covered by the Plan and by another plan which provides group health and welfare benefits. This is especially common when both you and your Spouse work, and each covers the other as a Dependent under their respective group health insurance plans. Coordination of Benefits also takes place when you or your Dependent's injuries result from a motor vehicle accident and motor vehicle no-fault or PIP insurance benefits are available.

If both you and your Spouse are Participants of the Plan, and either of you has charges covered by the Plan, both of you should file claims with the Fund. The Fund will coordinate benefits between your respective Plans.

B. COORDINATION OF BENEFITS RULES

When there is coverage under more than one group plan, Coordination of Benefits between the plans is decided by the first of the applicable rules below:

1. The Other Plan has primary responsibility if it has no Coordination of Benefits provision.
2. Non-Dependent Plan Pays First. The benefits of the plan that covers the individual as an employee, member or subscriber other than as a Dependent are determined before those of the plan which covers the individual as a Dependent.
3. If there is coverage for a Participant, Spouse or a Dependent by more than one plan, the plan providing coverage through active employment has primary responsibility.
    a. Active/Inactive Rule.
        i) Laid Off or Retired Employees. If an individual has coverage under one plan as a Laid-off or retired employee and under another plan as an active employee, the benefits provided by the plan which covers the individuals as an active employee are determined before those of the plan which covers the individual as a Laid-off or retired employee. The same rule applies to Dependents covered under both policies. Retiree plans that are pre-Medicare retiree plans are considered active plans for purposes of this Coordination of Benefits provision.
        ii) COBRA Eligibility Versus Other Plan Eligibility. The plan that covers the person as an active employee (or a Dependent of an active employee) pays before the plan that covers the person as COBRA beneficiary. If a COBRA beneficiary has Medicare that was effective before the COBRA election date, then Medicare would pay first.
4. If there is coverage by a governmental program, the governmental program shall have primary responsibility unless prohibited by federal law.

5. Birthday Rule. The Birthday Rule requires the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year (refers to the month and day only and not the year). If both parents have the same birthday, the plan that had covered either of the parents longer is primary.
6. Gender Rule. The Gender Rule requires the benefits of the plan covering the child as a Dependent of a male be determined before those plans covering the child of a Dependent of a female. (Note: *If one plan uses the Gender Rule and the Other Plan follows the Birthday Rule, then the Gender Rule should be followed*.)
7. Divorced, Separated, Never Married or Deceased Parents.
    a) Unmarried Parents Living Together. The Birthday Rule determines coverage for the child of the parents who live together but who have never been married.
    b) Joint Custody of Natural Parents and No Assigned Financial Responsibility. If a court decree awards joint custody of a child between the child's natural parents without assigning financial responsibility for health care expenses, and the child is covered under two or more group health plans of the natural parents, the Birthday Rule governs.
    c) Sole Custody and No Assigned Financial Responsibility. The following order is used:
        i. Plan of the custodial parent;
        ii. Plan of the Spouse of the custodial parent;
        iii. Plan of the non custodial parent; then
        iv. Plan of the Spouse of the non custodial parent.
    d) Assigned Financial Responsibility. The following order is used when actual court papers are received which clearly spell out that one parent is obligated to provide health care coverage for the Dependents:
        i. If the plan of the financially responsible parent has actual knowledge of the terms of the court decree, that plan is primary.
        ii. If the parent with the financial responsibility has no coverage but the parent's Spouse does, then the Spouse's plan is primary.
    e) Non-Parental Custody. Where coverage of a Dependent child is provided by an individual other than a parent (such as a grandparent or other guardian) the interpretation of the COB rules state the individual will "step into the shoes" of the parent, and take on the role of the parent in determining the order of benefit payments.
8. Length of Service Rule. This rule is applied when the member is the policyholder of two plans through two employers. The plan, which has covered the individual for the longest continuous period of time, will pay first. The following changes are not considered to be the start of the new plan:
    a) A change in the level or type of benefits provided;
    b) A change in the entity which pays, provides or administers the plan's benefits; and
    c) A change from one type of plan to another, such as from single employer to multiple employer or from fully insured to self-insured.

Note: If you or your Dependents do not follow the guidelines of the primary plan and receive a reduced benefit or no benefit, then the secondary plan may also reduce the benefit and/or pay no benefit.

Coordination With No-Fault Or PIP Motor Vehicle Insurance Coverage

When the Injury or illness results from a motor vehicle accident and motor vehicle no-fault or PIP insurance is available, that insurance has primary responsibility for the payment of benefits to you, your Spouse or your Dependent children.

The Plan Has Primary Responsibility

When the Plan has primary responsibility, you, your Spouse and your Dependent children will receive full coverage in the Plan without regard to any coverage under another plan.

The Other Plan Has Primary Responsibility

When the Other Plan has primary responsibility, that plan must first pay its full benefit. The Plan will then, unless payment is excluded, pay any remaining charges up to the amount that would have been paid if the Plan had primary responsibility.

When filing a claim for benefits, be sure to complete all of the information you are asked and/or required to provide, including the name of your Spouse's employer and the identification of any other group insurance plan. Incomplete information will delay the processing of your claim.

C. MEDICARE COVERAGE REQUIREMENT IF YOU BECOME MEDICARE ELIGIBLE BY REASON OF END STAGE RENAL DISEASE

Participants, Spouses and Dependents usually become eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. However, a Participant, Spouse or Dependent who is not eligible for Medicare because of age or disability may still qualify for Medicare coverage because of treatment for End Stage Renal Disease ("**ESRD**").

When a Participant, Spouse or Dependent becomes eligible for Medicare solely due to ESRD, Medicare eligibility can be separated into three parts: An initial three-month waiting period; a "coordination of benefits" period of 30 months; and the remaining period when Medicare is primary. These three parts are described below.

1. Initial Three-Month Waiting Period. Once a Participant, Spouse or Dependent has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the Plan is primary.
2. "Coordination of Benefits" Period of 30 Months. During the "coordination of benefits" period, Medicare is secondary to the Plan, and related claims are processed first under the Plan (in other words, the Plan is primary). Medicare will process these claims as a secondary carrier. For Participants, Spouses and Dependents who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.
3. The Remaining Period when Medicare is Primary. After the coordination of benefits period ends, Medicare is considered the primary payer and the Plan is considered the secondary payer. If a Participant, Spouse or Dependent is eligible for Medicare by reason of ESRD and Medicare is primary, that Participant, Spouse or Dependent must enroll in Medicare Parts A and B and submit proof of enrollment to the Plan. It is the responsibility of the Participant, Spouse or Dependent to ensure that he or she files his or her application for Medicare in a timely way so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Coverage for Training for Home Dialysis. If a Participant, Spouse or Dependent is a candidate for home dialysis, the Plan may cover training for the related home dialysis. The Plan may also cover home dialysis training conducted during the course of regular treatments for the Participant, Spouse or Dependent and another person who is helping with home dialysis treatments. The home dialysis

training must be conducted by a dialysis facility that has been certified by Medicare to provide home dialysis training. Participants, Spouses and Dependents may qualify for home dialysis training if they would benefit from self-dialysis training for at-home treatments, and the supervising doctor approves.

X. SUBROGATION/REIMBURSEMENT

The Fund has a right to recover any benefits it pays on behalf of you, your Spouse or your Dependent children for which another party is responsible (including but not limited to the usual and customary value of services rendered at the Wisconsin Health Fund's Medical and Dental Clinic). Typical examples include work-related injuries or conditions, injuries sustained in an automobile accident or injuries sustained on someone else's property. In such cases, your or the other person's car insurance or property insurance may have to pay all or a part of the resulting medical bills, even though benefits for the same expenses have already been paid by the Plan.

A. HOW SUBROGATION/REIMBURSEMENT WORKS

If the Fund believes another party may be responsible for your injuries or medical condition, or for paying for your injuries or medical condition, it will contact the other party and any insurance carrier that may be responsible with notice of its Right of Subrogation/Reimbursement. You may also receive a letter requesting information regarding how the Injury occurred. It is important that you respond to the request for information so that the Fund can determine whether a Right of Subrogation/Reimbursement exists. If you, your Spouse or your Dependent children have settled with the other party or insurance carrier, the Fund will require reimbursement from you, your Spouse or your Dependent children of the amount of benefits paid. Before settlement of any case, you, your Spouse or your Dependent children must contact the Fund to find out how much you owe the Fund out of any settlement. Failure to do so will result in you, your Spouse or your Dependent children having to reimburse the Fund for payment for your injuries.

B. THE BENEFIT OF SUBROGATION/REIMBURSEMENT

When the Fund collects monies through Subrogation/Reimbursement, Plan assets are recovered and preserved for the payment of future benefits. The Fund's Subrogation/Reimbursement Program is not subject to regulation by state law.

C. RIGHTS OF SUBROGATION/REIMBURSEMENT

Whenever the Fund has provided or is providing to you or Dependent medical, Hospital, dental, vision, pharmaceutical, disability or other benefits ("**Benefits**"), as a result of the occurrence of an Injury, Sickness or death which results in a possible recovery of indemnity, compensation or benefits from any party, including, without limitation, an insurer, employer, Worker's Compensation insurance or entity, and uninsurance and underinsurance coverage, the Fund may make a claim or maintain an action against such party.

By virtue of accepting such Benefits as a result of the occurrence of an Injury, Sickness or death which results in possible recovery of indemnity, compensation or benefits from any party, including, without limitation, an insurer, employer, Worker's Compensation insurance or entity, and uninsurance and underinsurance coverage, you or your Dependent recipient of such Benefits assigns to the Fund the right to make a claim against such party to the extent of the amount of such Benefits.

A Participant or Dependent must not do anything after the loss for which the Benefits were provided to prejudice the Fund's right of recovery. A Participant or Dependent shall promptly advise the Plan Administrator in writing whenever a claim against any party is made by or on your or your Dependent's behalf with respect to any loss for which Benefits were, or are being, received from the Fund.

The recipient of Benefits has an obligation to provide the Fund or its designee with the names and addresses of all potential parties and their insurers, adjusters, and claim numbers, as well as accident reports and any other information the Fund requests. If the information requested is not provided, the Fund in its discretion may withhold future benefit obligations pending receipt of the requested information.

The Participant or Dependent recipient of Benefits or the Fund may make a claim against a party or commence an action against a party and shall join the other as provided under the Wisconsin Statutes or applicable state or federal law. Each shall have an equal voice in the prosecution of such claim or action.

The proceeds from any settlement or judgment in any claim made against any party shall be allocated as follows.

1. A sum sufficient to fully reimburse the Fund for all Benefits advanced shall be paid to the Fund. No court costs or attorney's fees may be deducted from the Fund's recovery without prior, express written consent of the Fund. This right shall not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" or any other similar doctrine or theory.
2. Any remainder shall be paid to you or your Dependent on whose behalf a claim is made.
3. The Fund shall receive a credit, up to the full amount of any remainder paid to the recipient of Benefits pursuant to the preceding paragraph (2), to apply against any future Benefit obligations arising out of the Injury, Sickness or death which was the subject of the claim which resulted in the settlement or judgment.

The aforesaid allocation of proceeds will be paid from the first dollar of any proceeds received and will have a priority over competing claims regardless of whether the total amount of recovery of the Participant or Dependent, or those claiming under that person, is less than the actual loss suffered, or less than the amount necessary to make the Participant or Dependent, or those claiming under that person, whole. The Fund's rights will not be defeated or reduced by the application of any so-called "Made Whole Doctrine," "Garrity Doctrine," "Rimes Doctrine," or any doctrine purporting to defeat the Fund's rights by allocating the proceeds exclusively, or in part, to non-medical expense damages.

Furthermore, such allocation will apply to claims of the Participant or Dependent covered by the Fund, regardless of whether such recipient was legally responsible for expenses of treatment.

In the event a Participant or Dependent recipient makes a recovery in a claim from any party and the proceeds are not allocated in accordance with the prior paragraphs, the Trustees will have the right to make a claim for reimbursement, including but not limited to claims for restitution, unjust enrichment, or a constructive trust over any recovery by the Participant or Dependent recipient, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the Participant, the Participant's Dependent, the Participant's attorney, the Participant's Dependent's attorney, or any other individual or entity, or to take a credit on future Fund obligations to the Participant or Dependent to the extent of such benefits. Such credit is not limited to future obligations of the Fund to the actual recipient of such benefits but also may be taken against any future obligations to the Participant or Dependent.

XI. PLAN ADMINISTRATION

A. FINANCING BENEFITS

The Fund is a self-insured employee benefit plan that determines eligibility and processes claims for benefits provided by the Plan. The money the Fund uses to pay benefits under the Plan is obtained from contributions made by employers, and from the amounts you pay, if any. These employers are required to make periodic contributions on behalf of their employees. The amounts of these contributions are specified in written correspondence between the Fund and the employer, or in the employer's Participation Agreement with the Fund, or in the employer's Collective Bargaining Agreement. In the event of a conflict between the employer's Collective Bargaining Agreement and the employer's Participation Agreement with the Fund regarding the amount of contributions required to be made on behalf of the employer's employees, the employer's Participation Agreement with the Fund will prevail. Also, in the event of a conflict between the employer's Collective Bargaining Agreement and written correspondence between the Fund and the employer regarding the amount of contributions required to be made on behalf of the employer's employees, the written correspondence between the Fund and the employer will prevail.

Participants may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is making contributions to the Fund under a written agreement and, if so, the address for such employer or employee organization. The Fund may, from time to time, and with the consent of the Trustees, establish new and/or modify existing contribution (i.e., premium) rates. The contributions received by the Fund are used to provide current and future benefits, and to cover administrative costs. Contributions not immediately used for this purpose are invested and form a reserve from which future claims can be paid. Life and Accidental Death and Dismemberment insurance benefits are provided through a licensed life insurance carrier selected by the Fund.

Each year, a Summary Annual Report is prepared which provides details about the financial condition of the Plan. You may request a copy of this report by contacting the Fund.

B. AMENDMENTS TO THE PLAN AND PLAN TERMINATION

The provisions of the Plan may be amended from time to time by a majority vote of the Board of Trustees. The amendments may include increases, modifications, reductions or the elimination of certain benefits.

The Board of Trustees fully intends to continue the Plan indefinitely. However, the Trustees expressly reserve the right, if necessary and in their sole discretion, to do any of the following:

1. Terminate or amend the amount, eligibility requirement(s) and/or conditions of any benefit or the Plan itself. Any termination would be carried out as specified in the Trust Agreement and the Plan Document;
2. Alter the method of payment of any benefits;
3. Amend any provision of the Plan or the Plan Document or the Trust Agreement;
4. Interpret and apply the provisions of this Plan Document, the Trust Agreement and all related documents, or other documents pertaining to the Trust Agreement or this Plan; and
5. Terminate the Plan or any of the benefits provided by the Plan, and take other actions authorized by the Trust Agreement, ERISA or applicable law.

In the event of termination, all benefits of the Plan will end. No benefits shall be payable at any time after the Plan has been terminated and all Plan assets have been expended. All rights and powers of the Plan as provided herein shall be vested in the Trustees pursuant to the terms of the Trust Agreement and applicable law. The Trustees reserve these rights in order to maintain, within the limits of the funds available, a sound and financially viable Plan dedicated to providing you with benefits.

If the Plan is terminated, benefits for claims incurred before the termination date will be paid based on available assets. Full benefits may not be available if the Plan owes more than it has money to pay. If there is money left over, the Trustees may use it in a manner consistent with the purposes for which the Plan was created and/or they may transfer it to another fund providing similar benefits.

C. INFORMATION REQUIRED BY ERISA

As previously described herein, the Wisconsin Health Fund employee welfare benefit plan is a jointly administered group health plan that provides specified benefits to its Participants and their Dependents. The Plan Administrator is the Board of Trustees of Wisconsin Health Fund, 6200 West Bluemound Road, Milwaukee, WI 53213. The Plan Administrator's telephone number is (414) 771-5600. The Employer Identification Number assigned by the Internal Revenue Service to the Plan is 39-6063342. The Plan's number is 501, and its fiscal year ends December 31st. The agent for service of legal process is the Executive Director of Wisconsin Health Fund, 6200 West Bluemound Road, Milwaukee, WI 53213, or any of the Fund Trustees.

D. ERISA RIGHTS

Each Covered Person is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to the following:

1. Receive Information About The Plan and Benefits

You may examine, without charge, at the Fund's Benefit Department, all documents governing the Plan, including the Plan Document, insurance contracts and a copy of the latest annual report (Form 5500 Series) that the Fund filed with the U.S. Department of Labor, and that is available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

You may obtain, upon written request to the Fund's Benefit Department, copies of documents governing the operation of the Plan, including the Plan Document and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Fund may make a reasonable charge for the copies. You may also receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

You may continue health care coverage for yourself, your Spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

3. Prudent Actions By Plan Fiduciaries

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

4. Enforcement of Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan to provide the materials and pay you a daily amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance With Your Questions

If you have any questions about the Plan, you should contact the Fund's Customer Service Department. If you have any questions about this section or about your rights under ERISA, you should contact the nearest area 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, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

E. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT RIGHTS

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 only 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, in order to use certain providers or facilities, or in order to reduce your out-of-pocket costs, you may be required to obtain Pre-Certification. For information on Pre-Certification, contact the Fund.

F. Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires Wisconsin Health Fund to notify Participants and their covered Dependents of their rights related to benefits in connection with a mastectomy. Participants and their covered Dependents have rights to coverage provided in a manner determined in consultation with their attending physicians for: (1) Reconstruction, at all stages, of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits are subject to the Plan's regular Deductible and Co-insurance.

G. HIPAA

The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, requires plans that offer group health coverage to provide certain levels of protection for Covered Persons.

1. Special Enrollment Rights

If you waive medical coverage for yourself and/or your Dependents (including your Spouse) because of other health insurance coverage, in the future you might be able to enroll yourself and/or your Dependents in this Plan if your other coverage ends. You must notify the Fund and provide the necessary enrollment information within thirty (30) days after your other coverage terminates.

In addition, if you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents if you notify the Fund and provide the necessary enrollment information within thirty (30) days of one of these events.

2. Health Certificates

If your medical coverage under the Plan ends, you and your covered Dependents will receive a certificate that shows your period of medical coverage through the Plan. You might need to furnish the certificate to another group plan if you become eligible for other group coverage that contains an exclusion for certain medical conditions you have before you enroll (called pre-existing conditions).

You might also need the certificate to buy an insurance policy for yourself or your family that does not exclude coverage for pre-existing conditions. You and your Dependents may also request a certificate within twenty-four (24) months of losing medical coverage through this Plan. To request a certificate, call or write the Fund.

3. Confidentiality of Plan Information

These provisions of the Plan are intended by the Fund and the Board of Trustees to comply with the provisions of the HIPAA privacy regulations, and to establish the permitted uses and disclosures of individually identifiable Protected Health Information by the Fund and Board of Trustees.

Uses and Disclosures of Protected Health Information. The Board of Trustees may use and disclose Protected Health Information which it receives from the Fund as permitted or required by the Plan or in accordance with applicable law. Also, the Fund may disclose Summary Health Information to the Board of Trustees, if the Board of Trustees requests the Summary Health Information for the purposes of:

a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
b) Modifying, amending or terminating the Plan.

The Fund, or its health insurance carrier, may disclose to the Board of Trustees information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance carrier or HMO offered by the Fund. The Fund may also disclose Protected Health Information to the Board of Trustees to carry out Fund administration functions that the Board of Trustees performs, including but not limited to claim review activities, legal counsel reports, collections, audits and delinquency reports, Participation Agreements reviews and employer waivers. The Board of Trustees shall not further disclose Protected Health Information other than as permitted or required by the Plan or as required by law.

Agents of the Board of Trustees. The Board of Trustees shall ensure that any agents or subcontractors to whom the Board of Trustees provides Protected Health Information agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information.

Prohibited Uses and Disclosures. The Board of Trustees shall not use or disclose Protected Health Information received from the Fund for employment-related actions and decisions. The Fund shall not disclose Protected Health Information, and the Board of Trustees shall not use or disclose Protected Health Information received from the Fund, in connection with any other benefit or employee benefit plan of the Board of Trustees other than the Plan. Employees of Fund will use and disclose Protected Health Information in accordance with the law and the Fund's Notice of Privacy Practices, which is available upon request from the Fund.

Reporting. If the Board of Trustees becomes aware of any use or disclosure of Protected Health Information received from the Plan for employment-related actions and decisions. The Board of Trustees shall report it to the Plan.

Individual Rights. The Board of Trustees shall: 1) Make available Protected Health Information to individuals in accordance with the access rights in accordance with applicable law; 2) make Protected Health Information available for amendment and incorporate any amendments in accordance with applicable law; 3) make available the information required to provide an accounting of disclosures in accordance with applicable law.

Department of Health & Human Services Audits. The Board of Trustees shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received

from the Fund available to the Secretary of the Department of Health & Human Services or his designee for the purposes of determining the Fund's compliance with HIPAA privacy regulations.

Information Retention. If feasible, the Board of Trustees shall return or destroy all Protected Health Information received from the Fund that the Board of Trustees maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, the Board of Trustees shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Separation. The Fund and Board of Trustees shall ensure that adequate separation is established between the Fund and Board of Trustees. The Board of Trustees and the Fund's Executive Director, legal counsel and management personnel may have access to Protected Health Information as necessary to carry out the Fund's administration functions. Any noncompliance with the provisions of this HIPAA Section shall be reviewed and resolved by the Board of Trustees in the case of Trustee noncompliance, and by the Fund's Executive Director in the case of Fund employee noncompliance. Resolution of noncompliance issues may include measures ranging from additional education (or change in process to prevent further noncompliance) to dismissal of the noncompliant individual. The Fund and Board of Trustees agree to mitigate to the extent possible any damage that may occur as the result of noncompliance with this Section.

H. Qualified Medical Child Support Court Orders

Generally, all group health plans, including the Plan, are required to enroll a child for whom an employee is required to provide coverage pursuant to a qualified medical child support court order (or a QMCSO). If a QMCSO is issued by a court or authorized governmental agency which requires the Plan to provide medical coverage to a child who is not in your custody, the Plan will do so. To be considered "qualified," a medical child support order must include all of the following information:

1. Name and last known address of the parent who is covered under this Plan;
2. Name and last known address of each child to be covered under this Plan;
3. Type of coverage to be provided to each child;
4. Period of time the coverage is to be provided; and
5. The name of each plan to which the QMCSO applies.

QMCSOs should be sent to the Fund. Upon receipt, the Fund will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, the Plan must cover your children subject to the QMCSO under the Plan. As a Dependent covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

If you are required by a QMCSO to provide coverage for your children, you can enroll these children as timely enrollees under the Plan. If you are not enrolled already, you may also enroll as a timely enrollee at the same time as you enroll your children.

I. Medical Coverage Continuation During Medical Or Family Leave

If you take a Leave of Absence for your own serious medical condition or to care for a family member with a serious medical condition or to care for a newborn or adopted child under the Family and Medical Leave Act, you may be able to continue your medical coverage under the Plan. At the end of

the medical or family leave, you can also have your previous medical coverage reinstated on the date you return to work, assuming you pay any required contributions.

J. The Uniformed Services Employment and Reemployment Rights Act of 1994

If you enter military service, you will be provided continuation and reinstatement rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA protects employees who leave for and return from active duty in the uniformed services (including the Army, Navy, Air Force, Marines, Coast Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service). If you elect continuation coverage under USERRA, you and any eligible Dependents covered under the Fund when your leave began may continue coverage for up to 24 months.

If you are on active duty for 31 days or less, you (and your eligible Dependents covered under the Fund when your leave began) will continue to receive the health coverage that you would otherwise have received under the Fund. If you are on active duty for more than 31 days, you can continue coverage for yourself (and your eligible Dependents covered under the Fund when your leave began) for up to 24 months, but you will need to pay the applicable COBRA premium for such coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described above in this Booklet).

If you are called to active duty, you must notify the Fund in writing as soon as possible, but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible Dependents covered under the Fund on the day your leave started. Unlike COBRA coverage, if you do not elect USERRA for your Dependent(s), he/she/they cannot elect it separately.

Coverage for employees honorably discharged and returning from military service, or from absences for the purposes of determining fitness to serve in the military, will be reinstated if:

1. The employer receives advance notice of the employee's absence, whenever possible;
2. The cumulative length of absence for "eligible service" does not exceed 5 years; and
3. The former employee reports or submits an application for re-employment within the prescribed time-limits.

Contact the Fund to find out what paperwork is required to re-establish eligibility.

Former employees must notify the employer of their intent to return to work as follows:

1. For service of less than 31 days or for an absence of any length to determine a person's fitness for uniformed service, the person must report by the first regularly scheduled work period after the completion of service plus a reasonable allowance for time and travel (8 hours);
2. For service of more than 30 days but less than 181 days, the person must submit an application not later than 14 days following the completion of service; or
3. For service of more than 180 days, the person must return to work or submit an application to return to work not later than 90 days following the completion of service.

However, if service ends and you are hospitalized or convalescing from an Injury or Sickness sustained during uniformed service, you must report or submit an application, whichever is required, at the end of

the period necessary for recovery. Generally the period of recovery may not exceed 2 years. No waiting periods may be imposed on reinstated coverage, and upon reinstatement, coverage shall be deemed to have been continuous for all Plan purposes.

If you have any questions, or if you need more information, you may contact the Fund.

K. NOTICE ABOUT THE MEDICARE SECONDARY PAYER STATUTE

A federal law known as the Medicare Secondary Payer Statute requires that Wisconsin Health Fund report to the Secretary of the Department of Health & Human Services information the Secretary deems necessary to facilitate proper coordination of benefits with the Medicare program. The purpose of this law is to enable the federal government to correctly pay for the services provided to Medicare beneficiaries who also receive employer-sponsored health benefits. The information Wisconsin Health Fund is required to report may include your Social Security Number. According to the federal government, collection of this information for the purpose of coordinating benefits with Medicare is a required, legitimate and necessary use of this information, and is permitted by HIPAA.

XII. PLAN DEFINITIONS

The terms below are used in this Booklet and are defined here to help you understand the specific meaning they have when they appear.

ACCIDENT – A sudden unexpected event, Injury or external force occurring without forewarning and resulting in physical damage to the body (a hurt, wound or trauma).

ACCIDENTAL DEATH – A death directly and solely resulting from an accident, as defined from an external means or an external cause, as opposed to death caused or contributed to by a disease or Sickness.

AMBULANCE SERVICE – Transportation to the nearest Hospital equipped to furnish medical treatment via professional ambulance, railroad, or commercial airlines on a regularly scheduled flight if the Injury or Sickness requires special and unique Inpatient treatment not available locally.

APPEAL PROCESS – A multi-step appeal process that provides you with two separate reviews if your claim is denied.

CALENDAR YEAR – January 1 through December 31 of the same year.

CALENDAR YEAR BENEFIT MAXIMUM – The maximum amount payable for covered services incurred by you or a Dependent over the course of a calendar year.

COBRA – shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985.

CO-INSURANCE – The percentage you or your Dependent must pay for certain covered expenses and services after you or your Dependent has paid any applicable Co-pays and Deductibles and until you or your Dependent reaches your or your Dependent's annual out-of-pocket maximum.

COLLECTIVE BARGAINING AGREEMENT – The Agreement between your union and employer, which governs the wages and conditions of your work, including how employer contributions are made on your behalf.

COORDINATION OF BENEFITS – If a Participant/Dependent is covered by another group plan for health care, the Plan will coordinate its payment of benefits with the Other Plan to allow as complete claim reimbursement as possible without providing duplicate payments. Coordination of Benefits also applies to individual no-fault or PIP Motor Vehicle Insurance Coverage.

CO-PAY or **CO-PAYMENT** – The amount you or your Dependent is required to pay for certain expenses and services until you or your Dependent reaches your or your Dependent's out-of-pocket maximum.

COSMETIC SURGERY – Reconstructive or plastic surgery which is provided primarily to improve physical appearance and which restores appearance but does not correct or materially relieve a medical condition.

COVERED PERSON – Any person covered under this Plan pursuant to the terms of Section II herein.

CUSTODIAL CARE – Care that: (a) requires assistance and support for daily living; and (b) is not under active and specific medical, surgical or psychiatric treatment which will reduce the patient's disability to the extent necessary to enable the patient to function outside a protected environment. A Custodial Care determination is not precluded by the fact that a patient is under the care of a physician and that the services are provided at the "physician's request". Custodial Care expenses are not covered by the Plan.

DEDUCTIBLE – A Deductible is the amount of eligible medical expenses you must pay each Calendar Year before the Fund begins to pay any benefits. There is an individual Deductible and a family Deductible. After the Deductible has been met, the Fund will begin paying benefits according to the benefit level outlined in your At-a-Glance Schedule of Benefits. The Deductible applies to both in-network and out-of-network benefits.

DEPENDENT – For the purposes of the Plan, your Spouse and children who are under age 26 and who are eligible for benefits under the Plan.

DISABLED – For purposes of Loss of Time coverage under the Plan, you are considered disabled if you provide proof that you are unable, because of bodily Injury or disease, to perform any and every duty of the occupation in which you were engaged when you became disabled, and that you are not engaged in any gainful employment.

DISCHARGED – The permanent termination of your employment decided by your employer.

EMERGENCY, EMERGENCY CARE or **MEDICAL EMERGENCY** – A traumatic Injury or medical condition which, if not immediately treated, might cause complications, jeopardize full recovery or cause permanent damage (or in the case of pregnancy, threaten the health of the mother or her unborn child). A heart attack, stroke, poisoning, loss of consciousness, an incident involving severe bleeding and convulsions are considered to be examples of "medical emergencies". Similar conditions may also be determined by the Plan to be medical emergencies.

EMERGENCY PRESCRIPTION – An emergency prescription shall meet the following conditions: (1) The prescription is for a “medical emergency” which is defined above and (2) the reimbursement is for a 10-day supply only.

EMPLOYEE – A person employed by an employer that is party to a Collective Bargaining Agreement and that makes contributions to the Plan on the person’s behalf. Also, a person employed by a local union or a person employed by the Plan is considered an “employee.” You are an employee when you are working, on paid vacation or on a union-approved strike. You are not considered to be working if you are on Leave of Absence or Sick Leave, or are Laid off, Quits or are discharged.

EMPLOYER – An employer that has a Collective Bargaining Agreement with the union and that meets requirements for participation in the Plan as established by the Board of Trustees.

ERISA – ERISA is an acronym for a federal law entitled the Employee Retirement Income Security Act of 1974 that, among other things, specifies the rights you have as a Participant of the Plan.

EXPERIMENTAL – Services, supplies, care, drugs, devices and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:
(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
(2) If the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
(3) If Reliable Evidence shows that the drug, device, treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the service, supply, care, drug, device or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Reliable Evidence, as used above in this definition, shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same service, supply, care, drug, device or treatment; or the written informed consent used by the treating facility or by another facility studying substantially the same service, supply, care, drug, device or treatment.

The Plan Administrator shall have authority to determine, in its discretion, whether a service, supply, care, drug, device or treatment is Experimental. The fact that a service, supply, care, drug, device or treatment has prescribed, ordered, recommended or approved by a health care provider does not, in and of itself, make the service, supply, care, drug, device or treatment eligible for payment.

FUND – Wisconsin Health Fund, whose office is located at 6200 West Bluemound Road, Milwaukee, Wisconsin 53213.

GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE – 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. The Fund or its contracted vendor reserves 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 the Fund's sole discretion. The Fund or its contracted vendor develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by The Fund or its contracted vendor and revised from time to time) are available to Covered Persons upon request.

HIPAA – HIPAA is an acronym for a federal law entitled the Health Insurance Portability and Accountability Act of 1996 that is designed to protect health insurance coverage for workers and their families when they change or lose their jobs, reduce administrative complexity in health care, speed transactions and improve patient privacy.

HOME HEALTH CARE – Skilled care ordered in writing by a physician and provided by home health agency employees, including RNs, licensed registered physical therapists, master's level clinical social workers, registered occupational therapists, medical technologists or registered dieticians.

HOSPICE CARE – A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.

HOSPITAL – A properly licensed institution which is primarily engaged in providing health services on an Inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by, or under the supervision of, a staff of physicians, which has 24-hour nursing services and is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations. In no event shall the term "Hospital" include a facility which is primarily a place for rest or Custodial Care of the aged, a nursing home, convalescent home or similar institution.

INJURY – An accidental bodily "injury" which is sustained directly and independently of all other causes. The Plan only considers injuries that are not employment-related.

INPATIENT – A person receiving room and board while confined in a Hospital.

LAID-OFF – The involuntary separation from your employment which happens when your employer suspends you for lack of work. For the purposes of the Plan, you are no longer considered Laid-off if you work for any other employer or if you retire.

LEAVE OF ABSENCE – A voluntary and temporary absence from employment by you. For purposes of the Plan, you are no longer on Leave of Absence if you work for any other employer or if you retire.

MAINTENANCE CARE – Care which is not Medically Necessary or appropriate and/or medically effective, or care which is rendered primarily for convenience. Maintenance care includes, but is not limited to, chiropractic adjustments given regularly as therapy on a non-symptomatic basis and regular adjustments given after the treatment status has reached a plateau and the spinal or other condition has improved to a point where no additional care or frequency will improve the condition.

MEDICALLY NECESSARY – Health services which are determined by the Fund or its contracted vendor (e.g., the MHSAT Administrator) to diagnose or treat an illness or Injury and are performed or prescribed by an appropriate health care professional, consistent with the diagnosis and treatment of your condition, in accordance with Generally Accepted Standards of Medical Practice, not for the convenience of the patient, not more costly than an alternative drug, service, or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness or Injury, and provided in the most appropriate setting. With respect to Mental Health and substance abuse treatment services, Medically Necessary services include only those services determined by the MHSAT Administrator criteria and/or the MHSAT Administrator physician panel as adequate and essential for the treatment of a mental disorder or substance abuse related disorders, as defined by the standard nomenclature and the current version of the Diagnostic and Statistical Manual of Mental Disorders. The fact that your health care professional has prescribed, ordered, recommended or approved a treatment, service or supply does not make it Medically Necessary.

MEDICARE BENEFITS – Benefits for services and supplies which you or your Dependent receives or is entitled to receive under Medicare Part A or B.

MENTAL HEALTH – A neurosis, psychoneurosis, psychopathic, psychotic or mental or emotional disease or disorder of any kind.

OTHER PLAN – Any plan providing benefits or services for or by reason of hospital, medical, dental or vision care or treatment for which benefits or services are provided by:
(1) Group blanket or franchise insurance coverage;
(2) Group Blue Cross/Blue Shield and other prepayment coverage provided on a group basis;
(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans;
(4) Any coverage under governmental programs, and any coverage required or provided by any statute; or
(5) Any coverage under the Health Insurance or the Aged and Disabled provisions of the United States Social Security Act (Medicare) except that this item is subject to any government provision or regulation which requires that insurance benefits be utilized before benefits available under Medicare.

OUTPATIENT – A patient who comes to a Hospital, clinic, doctor's office or treatment facility, but does not occupy a bed or stay overnight.

PARTICIPANT – A person covered under a Collective Bargaining Agreement who is employed by an employer that makes contributions to the Plan on his behalf and who is eligible to receive a benefit of any type from the Plan. Also, a person employed by a local union or a person employed by the Plan and who is eligible to receive a benefit of any type from the Plan. You are an employee when you are working, on paid vacation or on a union-approved strike. You are not considered to be working if you are on Leave of Absence, Sick Leave, Laid-off, Quit or discharged.

PARTICIPATION AGREEMENT – A written agreement which requires contributions to the Plan, between a contributing Employer, the Plan and a Union.

PLAN – The employee welfare benefit plan offered by Wisconsin Health Fund to its Participants and their Dependents.

PRE-AUTHORIZATION or **PRE-CERTIFICATION** – An evaluation of the necessity, appropriateness, and efficiency of the use of medical or other services, procedures, and facilities. This includes, but is not limited to, reviews of necessary admissions, services ordered and provided, length of stay, discharge practices, need for emergency treatment, referrals, and any follow-up care.

PRE-EXISTING CONDITION – Any condition, physical or mental, resulting from an illness, Injury, or hereditary malformation that you or your Dependent has before your or your Dependent's health coverage under the Plan begins, except pregnancy. The cause of the condition does not matter and could be the result of an accident or illness. No limitation or exclusion for preexisting conditions, however, will be applied to children under age 19.

PROTECTED HEALTH INFORMATION – Any individually identifiable health information, including demographic information, collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and that 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 that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

QUIT – A permanent termination of your employment decided by you.

RETIREE – Any person covered under this Plan pursuant to the terms of Section VII herein.

RETIREMENT DATE – The date you choose to be the effective date of your pension.

SICK LEAVE – A temporary separation from work caused by your illness, Injury or pregnancy.

SICKNESS – A sickness, disorder or disease that is not employment-related. Pregnancy is treated in the same manner as a "sickness."

SKILLED NURSING – Care received at a state licensed skilled nursing facility, long term care facility, long term acute care facility or sub-acute facility which requires the skilled care of a registered nurse and/or state licensed physical therapist such that but for the skilled care provided that patient would be confined to an acute Inpatient Hospital.

SPOUSE – The person who is legally married to you while you are covered under the Plan.

SUBROGATION/REIMBURSEMENT – The Fund's right to recover any Plan payments from another party or from you, your Spouse or your Dependent children.

SUMMARY HEALTH INFORMATION – Any information that may be individually identifiable health information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan and from which the information described under applicable law has been deleted, except that the geographic information described under applicable law need only be aggregated to the level of a five digit zip code.

TRANSITIONAL CARE — That care which is less restrictive than Inpatient care, but more intensive than Outpatient care. Transitional Care is sometimes called "day treatment," "partial hospitalization," or "alternative level of care."

UNPROVEN – Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. (Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received. Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

USUAL AND CUSTOMARY CHARGE – The amount the Fund determines is the average amount charged within a geographic area for a certain service. The Plan will consider payment up to the usual and customary limit for all eligible services and you or your Dependent is responsible for any remaining balance.

WISCONSIN HEALTH FUND MEDICAL CENTER – The medical center operated by Wisconsin Health Fund and located at 6200 West Bluemound Road, Milwaukee, Wisconsin 53213.

WISCONSIN HEALTH FUND DENTAL CENTER – The dental center operated by Wisconsin Health Fund and located at 6200 West Bluemound Road, Milwaukee, Wisconsin 53213.

WORKER'S COMPENSATION – A state fund into which your employer contributes, which provides you with coverage for work-related illnesses or injuries.