

PLAN AMENDMENT

Plan Name: WELS VEBA Group Health Care Plan

Plan Number: 501

Effective Date: January 1, 2007

The provision entitled "IMPORTANT INFORMATION" of the Plan is deleted in its entirety and replaced with the following:

IMPORTANT INFORMATION

The Synod maintains this Plan for the exclusive benefit of Members. Although the Synod intends to maintain the Plan indefinitely, it retains the right to amend or terminate the Plan as provided herein. This Plan document determines the benefits a Member may receive. **If you have any questions about the Plan, the VEBA Commission encourages you to contact the WELS Benefit Plans Office.**

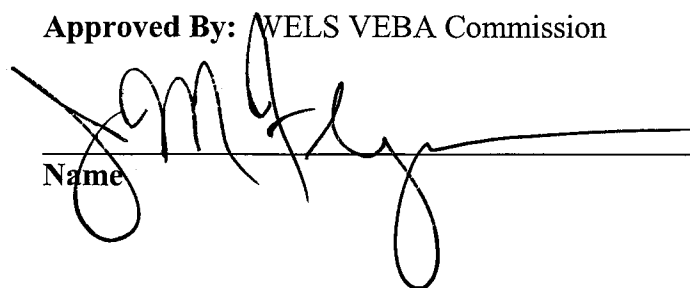
The provision entitled "Mail Order Program" in the Prescription Drug Benefits section of the Schedule of Benefits section of the Plan is deleted in its entirety and replaced with the following:

Mail Order Program

- \$25.00 per generic prescription
- \$62.50 per formulary prescription
- \$100.00 per non-formulary
- Dispensing Limitation: Not to exceed a 90 day supply

ALL OTHER PROVISIONS OF THE PLAN WILL REMAIN THE SAME.

Approved By: WELS VEBA Commission


Name _____ Date October 31, 2006

PLAN AMENDMENT

Plan Name: WELS VEBA Group Health Care Plan

Plan Number: 501

Effective Date: August 1, 2006

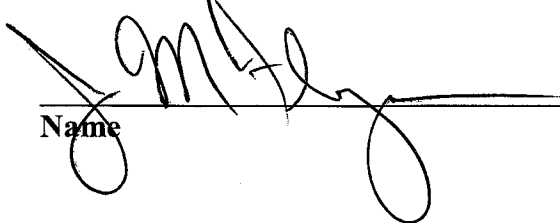
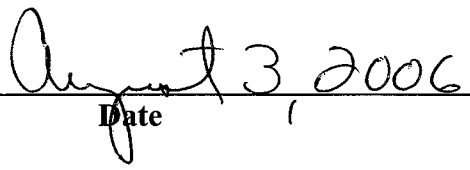
The provision entitled "Chiropractic Care" in the Miscellaneous Benefits section of the Plan is deleted in its entirety and replaced with the following:

Chiropractic Care

Eligible charges for chiropractic care including one initial exam, spinal or cervical x-rays, manipulations are covered as specified on the Schedule of Benefits. Maintenance care is routine and is not Medically Necessary for treatment of a condition. Maintenance care and non-manipulative therapy are not covered by the Plan.

ALL OTHER PROVISIONS OF THE PLAN WILL REMAIN THE SAME.

Approved By: WELS VEBA Commission

 _____ 
Name Date

PLAN AMENDMENT

Plan Name: WELS VEBA Group Health Care Plan

Plan Number: 501

Effective Date: February 1, 2006

Numbered paragraph 42 in the "Limitations and Exclusions of the Medical Plan" section of the Plan is deleted in its entirety and replaced with the following:

charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, (except for those who reside in the state of Michigan), or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;

The following is added to the Coordination of Benefits provision of the Plan:

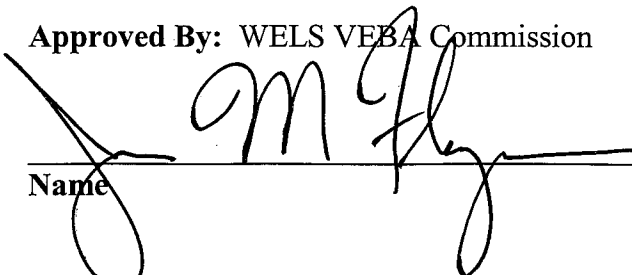
Coordination with No-Fault Automobile Insurance – Michigan Residents Only

If a claim is made due to a motor vehicle accident and the Member is covered by a No-Fault insurance required by state law, (Michigan residents only) the benefits payable under this Plan shall be primary.

ALL OTHER PROVISIONS OF THE PLAN WILL REMAIN THE SAME.

Approved By: WELS VEBA Commission

Name



Date

3/3/2006

PLAN AMENDMENT

Plan Name: WELS VEBA Group Health Care Plan

Plan Number: 501

Effective Date: January 1, 2006

The provision entitled “Individual Deductible” and Family Deductible Limit” in the Comprehensive Medical Benefits section of the Schedule of Benefits section of the Plan is deleted in its entirety and replaced with the following:

Individual Deductible

\$2,100 per person per Calendar Year

Family Deductible Limit

\$4,000 per family per Calendar Year

Notes:

- The deductible applies to all covered services unless otherwise specified by the Plan.
- The family deductible is an aggregate deductible. This means any combination of amounts paid by Family Members toward covered services can be used to satisfy the family deductible. * However, the maximum deductible amount for any one individual Family Member shall not exceed the IRS required minimum family deductible amount of \$2,100.00. Required minimum deductible amounts are determined by the IRS and are subject to change annually.
- If you have individual (as opposed to family) coverage, only the individual deductible will apply to you.
- If you have family (as opposed to individual) coverage, only the family deductible will apply to you.
- The individual and family deductible are subject to change each Calendar Year, based on the requirements established by the Internal Revenue Service (IRS). You will be notified if your deductible changes.

The provision entitled “Prescription Drug Co-payment Amounts” in the Prescription Drug Benefits section in the Schedule of Benefits section of the Plan is deleted in its entirety and replaced with the following:

Prescription Drug Co-payment Amounts

Please Note: Members will be required to pay for the full discounted cost of their prescription drugs until their calendar year deductible has been met. Coinsurance or Maximum Out-of-Pocket Amounts do not apply toward the prescription drug benefit

The co-pay amounts listed below will go into effect only after the deductible has been met:

Retail Program

- \$10.00 per generic prescription
- \$25.00 per formulary prescription
- \$40.00 per non-formulary prescription
- Dispensing Limitation: Not to exceed a 34 day supply

Mail Order Program

- \$20.00 per generic prescription
- \$50.00 per formulary prescription
- \$80.00 per non-formulary
- Dispensing Limitation: Not to exceed a 90 day supply

The following is added as the last numbered paragraph in the provision entitled “Other Covered Treatment, Services and Supplies” in the Comprehensive Medical Benefits section of the Plan:

prescription drugs or medicines obtainable only by a physician's written prescription and dispensed by a licensed pharmacist, not to exceed a 34-day supply under the Retail Program, or a 90-day supply under the Mail Order Program. Prescription drugs or medications obtained from a source outside of the United States are not covered, unless medically necessary to treat a condition of the covered person while such covered person is traveling or residing outside of the United States. Those drugs or medicines which do not require a written prescription to obtain are not covered;

Numbered paragraph 43 in the Limitations and Exclusions of the Medical Plan is deleted in its entirety.

The name, address and telephone number of "Walgreen Healthcare Initiatives" is deleted in its entirety from the Prescription Drug Benefits section of the Plan and replaced with the following:

PRESCRIPTION DRUG BENEFITS

Medco Health Solutions, Inc. will administer the Prescription Drug Plan once the covered Member satisfies the calendar year deductible.

Under this benefit, the Member is responsible for the amounts specified on the Schedule of Benefits.

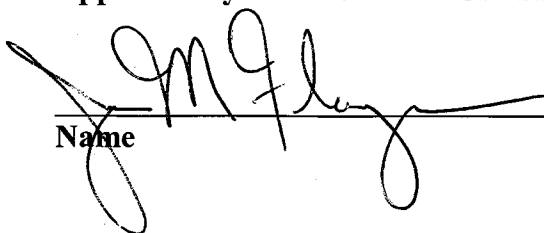
For additional information regarding your prescription drug program, including a listing of eligible and ineligible drugs, please contact the customer service department at Medco Health Solutions, Inc. at the number listed below.

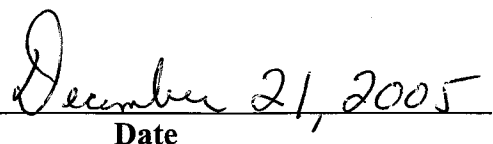
The prescription drug benefit applies if the Member has the prescription filled by a participating pharmacy. If the Member is unable to locate a participating pharmacy, the prescription along with a completed claim form, should be submitted directly to Medco Health Solutions, Inc. at the following address:

**Medco
PO Box 2187
Lee's Summit, MO 64063-2187
(800) 455-6892**

ALL OTHER PROVISIONS OF THE PLAN WILL REMAIN THE SAME.

Approved By: WELS VEBA Commission


Name


Date

WELS VEBA GROUP HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE OF PLAN: JANUARY 1, 2005

TABLE OF CONTENTS

HISTORY	2
PURPOSE	2
IMPORTANT INFORMATION	2
MANAGED CARE	3
PRE-ADMISSION REVIEW	3
MOTHERS AND NEWBORNS	3
ORGAN OR TISSUE TRANSPLANT	4
PRE-ADMISSION REVIEW NON-COMPLIANCE PENALTY	4
CONCURRENT STAY REVIEW	4
MEDICAL CASE MANAGEMENT	4
OUTPATIENT PRE-CERTIFICATION	4
SECOND OPINION - CMS REQUEST OR VOLUNTARY	4
INFORMATION REGARDING PPO AND NON-PPO PROVIDERS	6
SCHEDULE OF BENEFITS	7
MANAGED CARE BENEFITS	7
<i>Pre-admission Review Non-compliance Penalty</i>	7
<i>Second Opinion – Voluntary and CMS Request</i>	7
COMPREHENSIVE MEDICAL BENEFITS	7
<i>Individual Deductible</i>	7
<i>Family Deductible Limit</i>	7
<i>Coinsurance Paid By The Plan</i>	8
<i>Maximum Out-of-Pocket Amounts</i>	8
<i>PPO/Non-PPO Exception</i>	8
MISCELLANEOUS BENEFITS	9
<i>Inpatient, Transitional and Outpatient Treatment of Mental Health and Substance Abuse</i>	9
<i>Skilled Nursing Facility</i>	10
<i>Home Health Care</i>	10
<i>Chiropractic Care</i>	10
<i>Therapy Services (Physical, Speech and Occupational)</i>	10
<i>Repair/Replacement of Durable Medical Equipment</i>	11
<i>Orthoptic/Vision Therapy</i>	11
<i>Medicaid Prescription Drugs</i>	11
<i>Routine Vision Care</i>	11
<i>Wellness Benefit</i>	11
<i>Maternity/Newborn Infant Charges</i>	12
<i>Infertility Treatment</i>	12
<i>Sleep Studies</i>	12
<i>Nutritional Counseling</i>	12
<i>Biofeedback Treatment</i>	12
<i>Human Organ and Tissue Transplant</i>	13
MAXIMUM LIFETIME BENEFITS	13
PRESCRIPTION DRUG BENEFITS	13
<i>Prescription Drug Co-payment Amounts</i>	13

TABLE OF CONTENTS

ELIGIBILITY FOR COVERAGE 14

ELIGIBILITY PROVISIONS 14

Eligible Workers 14

PLAN ENROLLMENT 14

C. SPECIAL ENROLLMENT PROVISIONS 14

 1. *Loss of Coverage* 15

 2. *New Dependent Enrollment* 16

 3. *Annual Open Enrollment / Plan and Deductible Option Election Period* 17

 4. *Employment Transfer* 17

 5. *Qualified Medical Child Support Orders* 18

LEAVE OF ABSENCE PROVISIONS 18

Family and Medical Leave Act of 1993 18

Other Leaves of Absence 18

CONTINUATION OF COVERAGE 19

 A. *Surviving Spouse Coverage* 19

 B. *Retired Worker Coverage* 21

 C. *COBRA Continuation Coverage* 24

 A. *Full-time Student Re-enrollment* 29

 B. *Military Service* 29

TERMINATION OF COVERAGE 30

A. WORKER’S TERMINATION OF COVERAGE 30

B. DEPENDENT’S TERMINATION OF COVERAGE 30

COMPREHENSIVE MEDICAL BENEFITS 32

HOSPITAL ROOM AND BOARD 32

HOSPITAL MISCELLANEOUS CHARGES 32

OUTPATIENT FACILITY SERVICES 32

AMBULANCE 32

SURGICAL SERVICES 32

ORAL SURGERY 33

ANESTHESIA 34

OTHER COVERED TREATMENT, SERVICES AND SUPPLIES 34

MISCELLANEOUS BENEFITS 36

INPATIENT, OUTPATIENT, PARTIAL AND INTENSE TREATMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE 36

SKILLED NURSING FACILITY 36

HOME HEALTH CARE 36

HOSPICE CARE 37

CHIROPRACTIC CARE 37

THERAPY SERVICES (PHYSICAL, SPEECH AND OCCUPATIONAL) 37

REPAIR/REPLACEMENT OF DURABLE MEDICAL EQUIPMENT 37

ORTHOPTIC/VISION THERAPY 37

MEDICAID PRESCRIPTION DRUGS 38

ROUTINE VISION CARE 38

WELLNESS BENEFIT 38

MATERNITY/NEWBORN INFANT CHARGES 38

INFERTILITY TREATMENT 38

SLEEP STUDIES 38

NUTRITIONAL COUNSELING 39

TABLE OF CONTENTS

BIOFEEDBACK TREATMENT.....	39
HUMAN ORGAN AND TISSUE TRANSPLANT	39
LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN	42
PRESCRIPTION DRUG BENEFITS.....	46
COORDINATION OF BENEFITS.....	47
DEFINITIONS.....	47
EFFECT ON BENEFITS	48
ORDER OF BENEFITS DETERMINATION	48
RIGHT TO NECESSARY INFORMATION	49
FACILITY OF PAYMENT.....	49
COORDINATION UNDER THE BLUECARD PROGRAM	49
HOW TO FILE A CLAIM	50
GENERAL TERMS AND DEFINITIONS	52
GENERAL INFORMATION.....	61
ADMINISTRATION OF THE PLAN.....	61
BENEFIT CLAIM PROCEDURES AND APPEAL PROCEDURES FOR CLAIMS	61
PROOF OF CLAIM.....	61
CALCULATION OF PLAN MAXIMUM AMOUNTS	65
CLERICAL ERROR	65
CONFORMITY WITH GOVERNMENT LAW.....	66
COST SHARING PROVISIONS	66
DUPLICATION OF BENEFITS	67
FINANCING AND ADMINISTRATION	67
MASTER PLAN DOCUMENT	67
MEDICAL CARE PROVIDED BY THE UNITED STATES	67
NEW DRUGS, MEDICAL TESTS, DEVICES AND PROCEDURES	68
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE	68
PARTICIPANT CONTRIBUTION.....	68
PAYMENTS DIRECTLY TO PROVIDERS	68
PAYMENTS MADE PRIOR TO DETERMINING FINAL LIABILITY	68
PHYSICAL EXAMINATION	68
PLAN AMENDMENT OR TERMINATION.....	69
PLAN ADMINISTRATION AND INTERPRETATION.....	69
PLAN IS NOT A CONTRACT	70
PLAN MAXIMUMS AND BENEFIT MAXIMUMS.....	71
PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT	71
PRESUMPTION OF RECEIPT OF INFORMATION	73
PREVENTIVE SERVICES.....	73
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION	73
RESCISSION OF COVERAGE.....	76
RIGHT OF RECOVERY FOR PAYMENTS MADE.....	76
RIGHTS WITH RESPECT TO MEDICAID	76
SELF-FUNDING	77
SUMMARY PLAN DESCRIPTIONS.....	77
USE OF NETWORK OR PPO PROVIDERS	77
USUAL AND CUSTOMARY PROCEDURE.....	77

TABLE OF CONTENTS

WORKERS' COMPENSATION..... 78
PLAN INFORMATION..... 79
STATEMENT OF ERISA RIGHTS..... 81

HISTORY

The Wisconsin Evangelical Lutheran Synod (the "Synod") established a group medical plan for all Workers of the Synod and Workers in fellowship with the Synod. The Synod directed the Group Insurance Board of the Synod to formulate a specific plan. The Group Insurance Board proposed a group medical plan which was adopted by the 37th Biennial Synod Convention, August 7-14, 1963. The 47th Biennial Synod Convention directed the Group Insurance Board to investigate a change to a self-funded plan. The Group Insurance Board approved the establishment of a voluntary employees' beneficiary association ("VEBA"), described under section 501(c)(9) of the Internal Revenue Code (the "Code"), to provide and self-fund the Wisconsin Evangelical Lutheran Synod Group Medical Plan. This Wisconsin Evangelical Lutheran Synod Group Medical Plan became effective February 1, 1984. The Group Insurance Board has been replaced by the VEBA Commission, a representative body for the Synod and Workers, that serves as the Plan Administrator. The Wisconsin Evangelical Lutheran Synod Group Medical Plan is now named the WELS VEBA Group Health Care Plan. This amended and restated document describes group health Basic Plan Option available under the WELS VEBA Group Health Care Plan and is effective January 1, 2005. For purposes of this document, the WELS VEBA Group Health Care Plan Basic Plan Option is referred to as the "Plan." Other benefits that might be available under the WELS VEBA Group Health Care Plan are described in other summaries that will be provided to eligible Workers.

PURPOSE

The VEBA Commission maintains the WELS VEBA Group Health Care Plan to provide health and other welfare benefits for Workers and their families.

IMPORTANT INFORMATION

The Synod maintains this Plan for the exclusive benefit of Members. Although the Synod intends to maintain the Plan indefinitely, it retains the right to amend or terminate the Plan as provided herein.

This Plan document determines the benefits a Member may receive. If you have any questions about the Plan, the VEBA Commission encourages you to contact Claim Management Services, Inc., the Third Party Administrator for the Plan, at 1-800-472-7130.

MANAGED CARE

Pre-admission Review

Non-urgent Care Admission

Pre-admission reviews the request for an inpatient Hospital admission (including Mental Health and Substance Abuse) and the number of days for the Hospital stay to determine whether the admission and the number of days for the Hospital stay are within the guidelines of the Plan. All non-urgent care Hospital admissions must be pre-certified before a Hospital admission by calling the Managed Care Department at its toll-free number. The toll-free number can be found on each Member's identification card.

Urgent Care Admission

An "*Urgent Care*" admission is one where application of the time period for making non-urgent care determinations could either:

1. *Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or*
2. *In the opinion of a physician with knowledge of the medical condition, would subject the Member to severe pain that cannot be adequately managed without the care which is the subject of the claim.*

If a Member is admitted to the Hospital for an "Urgent Care" admission, as defined above, then no pre-certification is required for that admission. However, the CMS Managed Care Department must be notified within the first business day following the "Urgent Care" admission by calling its toll-free number that is located on the Member's identification card.

Hospital admission in a foreign country will not require pre-admission review.

Questions regarding decisions made by Utilization Review may be directed to the CMS Managed Care Department by calling its toll-free number that is located on the Member's identification card.

Mothers and Newborns

Group health plans, such as the Plan, and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Under the Plan, maternity stays exceeding either the 48 hour or 96 hour period, require certification by the CMS Managed Care Department or benefits may not be payable under the Plan for the remainder of the Hospital stay. Please see the "Newborns' and Mothers' Health Protection Act Notice" provision in the General Information section of the Plan.

Organ or Tissue Transplant

The Member should contact the CMS Pre-admission Review Department as soon as reasonably possible following the date on which the Member's attending physician has indicated that the Member is a potential candidate for an organ or tissue transplant or a potential donor for an organ or tissue transplant.

Pre-admission Review Non-compliance Penalty

If a Member does not comply with the Pre-admission Review certification requirements, eligible charges for inpatient care will be covered as specified on the Schedule of Benefits.

Concurrent Stay Review

Concurrent Stay Review occurs while the Member is in the Hospital. If the CMS Managed Care Department is advised of the need for hospitalization for a longer period of time than that was certified by Pre-admission Review, the physician will be asked to provide the CMS Managed Care Department with additional medical information to evaluate the need for the extended stay.

If the Member is confined in an inpatient facility longer than originally certified by the CMS Managed Care Department and the extended stay is not certified through the Concurrent Stay Review process, benefits may not be payable for the remainder of the Hospital stay.

Medical Case Management

Medical Case Management focuses on acute or chronic conditions that result from serious or debilitating Illnesses or Injuries by coordinating the needs of the Member, the family, the health care providers and the Plan.

Outpatient Pre-certification

The following outpatient procedures must be pre-certified by CMS. The Member should contact CMS as soon as he or she is aware of the possibility of such services by calling the CMS Managed Care Department at its toll-free number located on the Member's identification card.

- Eligible surgeries performed in an outpatient Hospital facility;
- Eligible surgeries performed in an Ambulatory Surgical Center;
- I.V. Therapies and related services (provided at any location, such as a Hospital or other outpatient facility, office or home); and
- Durable Medical Equipment (DME) over \$750 (including repairs and replacements).

Please note: Endoscopic procedures will not require pre-certification.

The above services will not require pre-certification review when rendered in a foreign country.

Second Opinion - CMS Request or Voluntary

If a Member is requested by the CMS Managed Care Department or voluntarily seeks to obtain a second opinion for an inpatient or outpatient procedure, eligible charges will be covered as specified on the Schedule of Benefits. The physician giving the second opinion must not be in medical practice with the physician who first recommended procedure. Charges are covered for a third opinion if the first and second opinions differ. After obtaining a second opinion, it is the

MANAGED CARE

Member's decision whether or not to have the procedure, no matter what the results are from the second opinion.

IMPORTANT: The utilization of Managed Care is not a guarantee of benefits under the Plan. Charges are subject to all Plan provisions.

INFORMATION REGARDING PPO AND NON-PPO PROVIDERS

The Plan Sponsor has entered into agreements with one or more preferred provider organizations. These preferred provider organizations are referred to as PPOs. PPOs contract with certain medical providers who agree to provide pre-determined medical services or supplies at prices that are typically less than the prices charged to individuals who are not covered by a PPO agreement. To determine if a particular medical provider participates in a PPO with which the Plan Sponsor has contracted, please visit the website that is listed on your identification card.

It is the choice of the Member whether or not to use a PPO provider. The Plan, Plan Sponsor, and Third Party Administrator make no representations or warranties regarding the qualifications or the care provided by any provider, including those providers who participate in the PPO. Members should make their own decisions concerning the qualifications of the providers they select to provide them with medical (or dental) services or supplies.

Information Regarding The Bluecard Program

CMS is able to offer the Plan participation in a program called "BlueCard". Blue Cross and Blue Shield Licensees (including CMS), participate in a program called "BlueCard". Whenever a Member accesses health care services outside the geographic area served by CMS, the claims for those services may be processed through BlueCard and presented to CMS for payment on behalf of the Plan, in conformity with the network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when a Member receives covered services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), CMS will remain responsible to the Plan for fulfilling all contract obligations. However, in accordance with any applicable BlueCard Policies, the Host Blue will only be responsible for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described in further detail in the Cost Sharing Provisions located in the General Information section of the Plan.

SCHEDULE OF BENEFITS

The outline of benefits in this schedule is a summary of coverage provided by Basic Plan Option coverage under the WELS VEBA Group Health Care Plan. A detailed explanation of the benefits under this Plan Option is provided in the pages which follow.

Benefits listed in the Plan are limited to the Usual and Customary fees and subject to the Limitations and Exclusions specified in the Plan.

All inpatient Hospital admissions are subject to the provisions of the Managed Care program.

Managed Care Benefits

Pre-admission Review Non-compliance Penalty

If a Member does not comply with the Pre-admission Review certification requirements, the first \$200.00 in eligible charges for inpatient care will not be payable. Any reduction in benefits will not apply toward satisfaction of the maximum out-of-pocket amounts and must be paid by the Member even if the limitation on these expenses has been met.

Second Opinion – Voluntary and CMS Request

If a Member is requested by the CMS Managed Care Department, or voluntarily seeks to obtain a second opinion for an inpatient or outpatient procedure, eligible charges for the second opinion examination and related services are covered at 100% after satisfaction of the Calendar Year deductible amount specified by the Plan.

Comprehensive Medical Benefits

Individual Deductible

\$1,800 per person per Calendar Year

Family Deductible Limit

\$2,000 per family per Calendar Year

Notes:

- The deductible applies to all covered services unless otherwise specified by the Plan.
- The family deductible is an aggregate deductible. This means any combination of amounts paid by Family Members toward covered services can be used to satisfy the family deductible. * However, the maximum deductible amount for any one individual Family Member shall not exceed the IRS required minimum family deductible amount of \$2,000.00. Required minimum deductible amounts are determined by the IRS and are subject to change annually.

SCHEDULE OF BENEFITS

- If you have individual (as opposed to family) coverage, only the individual deductible will apply to you.
- If you have family (as opposed to individual) coverage, only the family deductible will apply to you.
- The individual and family deductible are subject to change each Calendar Year, based on the requirements established by the Internal Revenue Service (IRS). You will be notified if your deductible changes.

Coinsurance Paid By The Plan

Unless otherwise specified, after satisfaction of the deductible amount eligible charges are covered at 80% (PPO) or 70% (Non-PPO) up the Maximum Out-of-Pocket Amount specified by the Plan.

Maximum Out-of-Pocket Amounts

Unless otherwise specified, after satisfaction of the following out-of-pocket amounts, eligible charges will be covered at 100% for the remainder of that Calendar Year:

Per Individual	Per Family
\$5,000	\$10,000

Maximum Out-of-Pocket Amounts are combined for both PPO and Non-PPO providers. Eligible charges applied toward the following will not be applied toward satisfaction of the Maximum Out-of-Pocket Amounts:

- any penalty amounts;
- Inpatient and Partial/Intensive treatment of Mental Health and Substance Abuse charges. These services have a separate maximum out-of-pocket;
- Outpatient Mental Health charges;
- infertility treatment charges;
- charges for routine vision care;
- additional sleep studies as specified;
- any charges not covered by the Plan; and
- charges for repair/replacement of DME.

PPO/Non-PPO Exception

Only under the following circumstances will eligible charges be determined at a higher level of benefits:

- when a Member receives medical care while in an area where reasonable network access does not exist, as determined by the Plan Administrator;
- when a Member resides in a foreign country

Under these circumstances, eligible Non-PPO charges will be covered at 80%, after satisfaction of the deductible.

Miscellaneous Benefits

Inpatient, Transitional and Outpatient Treatment of Mental Health and Substance Abuse

In the event a Member fails to obtain pre-certification/pre-authorization, the Plan will not reimburse charges for Inpatient and Partial/Intense Treatment of Mental Health and Substance Abuse.

Inpatient Treatment of Mental Health

- The deductible amount applies
- Amount paid by the Plan: 80% (PPO or Non-PPO)
- Eligible charges will apply to a separate maximum out-of pocket amount of \$2,000.00 per Calendar Year per person
- Limited to 30 days per Calendar Year

Inpatient Treatment of Substance Abuse

- The deductible amount applies
- Amount paid by the Plan: 80% (PPO or Non-PPO)
- Eligible charges will apply to a separate maximum out-of pocket amount of \$2,000.00 per Calendar Year per person
- Limited to 2 courses of treatment per lifetime Maximum Benefit

Partial/Intense Treatment of Mental Health

- The deductible amount applies
- Amount paid by the Plan: 80% (PPO or Non-PPO)
- Limited to 60 days per Calendar Year
- Eligible charges will apply to a separate maximum out-of pocket amount of \$2,000.00 per Calendar Year per person

Partial/Intense Treatment of Substance Abuse

- The deductible amount applies
- Amount paid by the Plan: 80% (PPO or Non-PPO)
- Limited to 60 days per lifetime maximum
- Eligible charges will apply to a separate maximum out-of pocket amount of \$2,000.00 per Calendar Year per person

Outpatient Treatment of Mental Health and Substance Abuse

Pre-certification/Preauthorization is not required

- The deductible amount applies
- Amount paid by the Plan: 70% (PPO or Non-PPO)
- Limited to a combined maximum of 36 visits per Calendar Year

Benefit Determination:

- When multiple charges and diagnoses are received for outpatient services and supplies that have been provided for either or both Mental Health and Substance Abuse, outpatient benefits under the Plan will be determined according to the provider's primary diagnosis listed for that date of service.
- The determination of whether a claim for benefits is covered by and subject to the Mental Health benefit shall be made without regard to whether the cause of the condition for which treatment and supplies were provided is, or was, organic in origin.

Skilled Nursing Facility

- The deductible amount applies
- Amount paid by the Plan: 100%
- Limited to a maximum of 30 days per Calendar Year

Home Health Care

- The deductible amount applies
- Amount paid by the Plan: 100%
- Limited to a maximum of 40 visits per Calendar Year

Chiropractic Care

- The deductible and coinsurance amount applies
- Limited to the following:
 - a maximum of 24 manipulative visits per Calendar Year;
 - one (1) full set of spine or cervical x-rays per Calendar Year; and
 - one initial examination per Calendar Year.

Therapy Services (Physical, Speech and Occupational)

- The deductible and coinsurance amount applies
- Limited to a combined maximum of 40 visits per Calendar Year

SCHEDULE OF BENEFITS

Repair/Replacement of Durable Medical Equipment

- The deductible amount applies
- Amount paid by the Plan: 50% (PPO or Non-PPO). Eligible charges will not apply to the Maximum Out-of-Pocket Amounts for repairs/replacements. Prior authorization is required.

Orthoptic/Vision Therapy

- The deductible and coinsurance amounts apply
- Limited to a lifetime Maximum Benefit of one (1) initial examination and four (4) therapy sessions.

Medicaid Prescription Drugs

- The deductible amount applies
- Amount paid by the Plan: 70%

Note: This benefit applies to eligible prescription drugs **only** when submitted by Medicaid. For all other prescription drugs please refer to the Prescription Drug Benefit section of the Plan.

Routine Vision Care

- The deductible amount applies
- Amount paid by the Plan: 50% (PPO or Non-PPO) of the first \$250 eligible charges per Calendar Year
- Limited to a Maximum Benefit of \$125 per person per Calendar Year

Includes the following eligible services:

- Frames, lenses and contact lenses, including those needed for the first purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery.

Please note: Charges for routine vision care will not apply to the Maximum Out-of-Pocket Amounts

Wellness Benefit

- The deductible amount does not apply
- Amount paid by the Plan: 80% (PPO) or 70% (Non-PPO)
- Limited to a maximum of \$300.00 per Calendar Year. Thereafter, the Calendar Year deductible and coinsurance amounts will apply.
- The following routine services are covered:
 - examinations;
 - routine vision examinations;

SCHEDULE OF BENEFITS

pap smears;
mammograms;
other related x-ray and laboratory services;
immunizations; and
well-baby care.

Maternity/Newborn Infant Charges

Eligible charges are covered subject to the deductible and coinsurance amounts for medical care in connection with pregnancy, childbirth or a related medical condition of a Covered Worker or covered Dependent. This includes charges for (3) three ultrasounds per pregnancy. Eligible charges for the inpatient care of a healthy newborn infant such as inpatient facility, x-ray and laboratory, physician's visits and circumcision are covered under the covered mother's Plan of benefits. Thereafter, eligible charges for the newborn are covered under the covered newborn's Plan of benefits.

Note: If the mother is not covered under the Plan, or if the newborn infant is born unhealthy, or if the covered mother and newborn child are discharged separately, the deductible and coinsurance amounts will be applied separately.

Infertility Treatment

- The deductible amount applies
- Amount paid by the Plan: 50%
- Limited to a lifetime Maximum Benefit of \$5,000.00 per family per calendar year. Eligible charges will not apply to the maximum-out-of-pocket amounts.

Sleep Studies

- Amount paid by the Plan:
- Initial sleep study: subject to the deductible and coinsurance amounts specified by the Plan;
- Additional sleep studies: 50% (PPO or Non-PPO after satisfaction of the deductible). Eligible charges will not apply toward the maximum out-of-pocket amounts.

Nutritional Counseling

- The deductible and coinsurance amounts apply
- Limited to 6 sessions per Calendar Year

Biofeedback Treatment

- The deductible and coinsurance amounts apply
- Limited to 10 sessions per Calendar Year

SCHEDULE OF BENEFITS

Human Organ and Tissue Transplant

Utilization of a Specified Facility

- The deductible amount applies
- Amount paid by the Plan: 100%

Non-utilization of a Specified Facility

- PPO and Non-PPO: The deductible and coinsurance amounts apply*

***Please Note:** Charges incurred by the donor with a Non-PPO provider will not be covered. Eligible donor charges may be covered only if a designated transplant center and/or PPO Hospital are used. Additional information may be found under the Miscellaneous Benefits section of the Plan.

Maximum Lifetime Benefits

Maximum Lifetime Benefits are applicable for the total period of time in which covered by the Plan. (If a Member who was covered under the Plan as a Dependent of a Covered Worker becomes covered under the Plan as a Covered Worker, then he/she shall have a new Maximum Lifetime Benefit with respect to eligible expenses he/she incurs while a Covered Worker.)

All paid medical benefits - \$2,000,000.00 per person, except as specified below

Inpatient treatment of Substance Abuse – limited to 2 course of treatment per person **

Orthoptic/Vision Therapy- limited to 1 initial exam and 4 therapy sessions while covered by the Plan**

Infertility Treatment – limited to \$5,000.00 per family**.

Partial/Intense Treatment of Substance Abuse – Limited to 60 days per lifetime maximum. **

Prescription Drug Benefits

Eligible prescription drugs are payable after satisfaction of the following co-payments:

Prescription Drug Co-payment Amounts

Retail Program

- \$10.00 per generic prescription
- \$15.00 per formulary prescription
- \$25.00 per non-formulary prescription
- Dispensing Limitation: Not to exceed a 34 day supply

Mail Order Program

- \$20.00 per generic prescription
- \$30.00 per formulary prescription
- \$50.00 per non-formulary
- Dispensing Limitation: Not to exceed a 90 day supply

ELIGIBILITY FOR COVERAGE

Eligibility Provisions

Eligible Workers

A Worker is eligible to participate in the Plan as of the Worker's Date of Employment

PLAN ENROLLMENT

A. Initial Enrollment Period

To enroll for health benefits under this Plan, a Worker must submit an appropriately completed enrollment application form to the Administrator no later than the 60th day following the Worker's Date of Employment. The Worker may enroll (i) the Worker, or (ii) the Worker and his/her Dependents.

If a Worker timely enrolls for Plan coverage under this Section A, Plan coverage will be effective on the latest of the following dates:

1. The Worker's Date of Employment at an eligible Sponsoring Organization;
2. The date the Administrator receives the completed enrollment application form; or
3. The effective coverage date requested by the Worker, provided that date is no later than 60 days after the earlier of (1) or (2) above.

If the Worker delivers the enrollment application form to the Administrator by mail, then, for purposes of (2) above, the Administrator will be deemed to have received the Worker's enrollment form on the date following the date postmarked or, if applicable, the date marked for overnight delivery.

B. Enrollment Application Form

In the enrollment application, the Worker must select coverage under this Plan (and select a Plan Option and a Deductible Option) or the High Deductible Plan Option (the enrollment rules for which are described in a separate document). The options selected will determine the applicable deductible(s), which of the Worker's Dependents, if any, are covered, and (when considered in conjunction with the billing region) the cost of the Worker's coverage..

C. Special Enrollment Provisions

A Worker who is not enrolled for health benefits under the WELS VEBA Group Health Care Plan (whether under this Plan or the High Deductible Plan Option) for

himself/herself or for any of his/her Dependents may enroll for coverage as described in this Section C.

1. Loss of Coverage

If the Worker and/or Dependent:

- Had coverage under another health plan (or health insurance) that was COBRA Coverage and the COBRA Coverage has been exhausted; or
- Had coverage under another health plan (or health insurance) that was not COBRA Coverage and that Creditable Coverage has been lost due to Loss of Eligibility for that coverage, termination of employer contributions toward that coverage, or exhaustion of COBRA Coverage (if elected); then

the Worker may enroll for health benefit coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the High Deductible Plan Option) for (a) the Worker, or (b) the Worker (i.e., if not already a Member) and his/her Dependents. For purposes of this subsection 1, “coverage under another health plan (or health insurance)” means coverage under a health program that would constitute Creditable Coverage..

- a) **Procedure.** To enroll, the Worker must submit an appropriately completed enrollment application form to the Administrator within 60 days after the Worker and/or Dependent has exhausted or lost coverage as described above. (In the case of a Loss of Eligibility that arises because a Worker and/or Dependent reaches a lifetime cap on benefits, the 60-day period shall run from the date his/her first claim is denied by application of that lifetime cap.) The completed application form must include a Certificate of Creditable Coverage or other documentation approved by the Administrator to verify the Worker’s and/or Dependent’s previous health plan or health insurance coverage.

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 1 must select a Plan Option and Deductible Option in the enrollment application.

If a Covered Worker is enrolling a Dependent under this Plan pursuant to this subsection 1, the Covered Worker must select a Plan Option in the enrollment application. *In this case, no Member’s prior Deductible Option election may be modified under this subsection 1 and coverage for the Member under the High Deductible Plan Option may not be elected under this subsection 1.*

- (b) **Effective Date.** If a Worker timely enrolls for Plan coverage under this subsection (1), Plan coverage will be effective on the later of the following dates:

- (i) The date the Administrator receives the completed enrollment application form; or,
- (ii) The effective coverage date requested by the Worker, provided that date is no later than 60 days after the date Administrator receives the completed enrollment application form.

If the Worker delivers the written enrollment application form to the Administrator by mail, then, for purposes of (i) and (ii) above, the Administrator will be deemed to have received the Worker's enrollment form on the date following the date postmarked or, if applicable, the date marked for overnight delivery.

2. *New Dependent Enrollment*

If a Worker gains a new Dependent, the Worker may enroll for health benefit coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the High Deductible Plan Option) of (a) the Worker, or (b) the Worker (i.e., if not already a Member) and his/her Dependents.

(a) ***Procedure.*** To enroll, the Worker must submit an appropriately completed enrollment application form to the Administrator as follows:

- A Worker with a new Spouse must submit a completed application to the Administrator within 60 days of the marriage date.
- A Worker with a newborn Dependent Child must submit a completed application to the Administrator within 60 days of the child's birth.
- A Worker with a Dependent Child who is adopted by, or placed for adoption with, the Worker must submit a completed application to the Administrator within 60 days of the child's adoption date or, if earlier, placement for adoption date.

A Worker enrolling himself/herself and, if applicable, any Dependent under this Plan pursuant to this subsection 2 must select a Plan Option and Deductible Option in the enrollment application.

If a Covered Worker is enrolling a Dependent under this Plan subsection 2, the Covered Worker must select a Plan Option in the enrollment application. *In this case, no Member's prior Deductible Option election may be modified under this subsection 2 and coverage for the Member under the High Deductible Plan Option may not be elected under this subsection 2.*

(b) ***Effective Date.*** If a Worker timely enrolls for Plan coverage under this subsection (2), coverage will be effective as follows:

(i) If the new Dependent is the Worker's new Spouse, the effective date of Plan coverage will be the marriage date.

(ii) If the new Dependent is a newborn, the effective date of Plan coverage will be the date of birth.

(iii) If the new Dependent is an adopted child, the effective date of Plan coverage will be the earlier of the adoption date or the adoption placement date.

The Worker may request a later effective date for Plan coverage, provided the date requested is no later than 60 days after the date that would otherwise apply to the Worker under (i), (ii), or (iii) above.

3. Annual Open Enrollment / Plan and Deductible Option Election Period

During the October/November open enrollment period, which is presently provided each Calendar Year:

- A Covered Worker may enroll his/her Dependents for coverage under the Plan; or
- An eligible Worker may enroll (a) the Worker, or (b) the Worker and his/her Dependents, for coverage under the WELS VEBA Group Health Care Plan (whether under this Plan or the High Deductible Plan Option); or
- A Covered Worker under the Plan may elect to change the Plan Option and/or Deductible Option applicable to the Covered Worker and, if applicable, his/her covered Dependents or change to the High Deductible Plan Option (which is described in a separate documents).

(a) **Procedure.** To make any of these enrollment or coverage changes, the Worker must submit an appropriately completed enrollment application to the Administrator during the open enrollment period.

(b) **Effective Date.** If a Worker timely enrolls for Plan coverage or modifies his/her Plan Option and/or Deductible Option under this Plan during an open enrollment period under this subsection 3, the effective date for Plan coverage (i.e., in the case of enrollment) or the new coverage option (i.e., in the case of a Plan Option and/or Deductible Option change) will be January 1 following the enrollment/election period.

4. Employment Transfer

An eligible Worker who is not a Covered Worker may enroll (a) the Worker, or (b) the Worker and his/her Dependents, for coverage under the Plan if the Worker accepts a new call or position with a Sponsoring Organization.

A Covered Worker may change his/her Plan Option and enroll his/her Dependents if the Covered Worker accepts a new call or position with a Sponsoring Organization. *In this case, no Member's prior Deductible Option election may be modified under this subsection 4 and coverage for the Member under the High Deductible Plan Option may not be elected under this subsection 4.*

- (a) **Procedure** To enroll for Plan health benefit coverage or to make a Plan Option change, an eligible Worker or Covered Worker must submit an appropriately completed enrollment application form to the Administrator within 60 days of the effective date of the new call or position.
- (b) **Effective Date.** If a Worker or Covered Worker timely submits a completed enrollment application form to the Administrator following a transfer under this subsection 4, the effective date of the enrollment and/or new Plan Option, as applicable, will be the first day of the month following the month in which the Administrator receives the completed enrollment form. If the Worker or Covered Worker delivers the completed enrollment application form to the Administrator by mail, then, for purposes of the previous sentence, the Administrator will be deemed to have received the Worker's enrollment form on the date following the date postmarked or, if applicable, the date marked for overnight delivery.⁵

5. *Qualified Medical Child Support Orders*

Notwithstanding any other provision of the Plan, the Plan will provide benefits in accordance with any Qualified Medical Child Support Order (as defined in section 609(a)(2) of the Employee Retirement Income Security Act of 1974). The Administrator has developed written guidelines and will determine whether an order is a Qualified Medical Child Support Order. A Member may request a copy of the procedures, without charge, from the Benefit Plans Office.

LEAVE OF ABSENCE PROVISIONS

Family and Medical Leave Act of 1993

If an Employer grants an FMLA leave, the Covered Worker and the Covered Worker's covered Dependents shall continue under the Plan as if the Covered Worker were actively employed. On the date that the Covered Worker notifies the Employer that the Covered Worker will not return or, if later, the date that the statutory leave period expires, the Covered Worker and the Covered Worker's covered Dependents may enroll for COBRA Coverage if otherwise eligible.

Other Leaves of Absence

If an Employer grants a leave of absence that does not qualify as an FMLA leave, the Covered Worker and the Covered Worker's covered Dependents may remain in the Plan by enrolling COBRA Coverage if otherwise eligible.

CONTINUATION OF COVERAGE

A. Surviving Spouse Coverage

In lieu of COBRA Coverage, a Surviving Spouse may continue Plan coverage on a self-pay basis (“Surviving Spouse Coverage”), as described below.

(1) **Enrollment.** To enroll for Surviving Spouse Coverage, the Surviving Spouse must submit an appropriately completed enrollment application form to the Administrator within 60 days following the end of the calendar quarter in which the Covered Worker’s death occurred.

(2) **Plan Option.** The Surviving Spouse may elect individual coverage or individual plus child(ren) coverage (i.e., for any Dependent Child who is a Dependent and was covered by the Plan at the time of the Covered Worker’s death). The Plan will not cover new Family Members acquired by the Surviving Spouse.

(3) **Required Contributions.** To obtain and retain Surviving Spouse Coverage under this Section A, the Surviving Spouse must pay required contributions to the Administrator. The Administrator will determine the amount of required contributions due for Surviving Spouse Coverage.

(4) **Termination of Surviving Spouse Coverage for Surviving Spouse.** Surviving Spouse Coverage for a Surviving Spouse under this Section A will terminate as of the earliest of the following dates.

(a) The date the Synod ceases to provide a group health Plan to any Worker.

(b) The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.

(c) The date the Surviving Spouse, after electing Surviving Spouse Coverage, becomes covered under another group health plan, including, without limitation, this Plan.

(d) The date the Surviving Spouse is eligible to elect Medicare coverage (Part A, Part B or both).

(e) The effective date of any Plan amendment that results in the termination of the Surviving Spouse’s Surviving Spouse Coverage.

(5) **Termination of Surviving Spouse Coverage for Dependent Child.** Except as provided in subsection (6) below, termination of the Surviving Spouse Coverage for a Surviving Spouse under subsection (4) above would have the effect of terminating related Dependent Child coverage under this Section A. In addition,

coverage of a Dependent Child under this Section A will terminate as of the earliest of the following dates.

- (a) The date the Dependent Child, after coverage for the Dependent under this Section A is elected, becomes covered under another group health plan, including, without limitation, this Plan or Medicare (Part A, Part B or both).
 - (b) The last day of the month in which the Dependent Child marries, provided such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.
 - (b) The last day of the calendar quarter in which the Dependent Child ceases to qualify as a Dependent of the Surviving Spouse, provided such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.
 - (c) The effective date of any Plan amendment that results in the termination of the Dependent Child's Plan coverage.
 - (d) The date the Administrator does not receive required contributions with respect to such coverage.
 - (e) The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.
- (6) **Medicare Supplement Coverage.** When the Surviving Spouse is entitled to Medicare and, as a result, no longer eligible to continue Surviving Spouse Coverage under this Plan, the Surviving Spouse may continue supplemental Medicare benefits available under the WELS VEBA Group Health Care Plan Medicare supplemental plan, subject to the terms and conditions of that Plan. If the Surviving Spouse timely elects supplemental Medicare benefits under the Medicare supplemental plan, a covered Dependent Child of the Surviving Spouse may continue coverage under this Plan until the earliest of the following dates:
- (a) The date the Dependent Child, after Surviving Spouse Coverage for the Dependent is elected, becomes covered under another group health plan, including, without limitation, this Plan or Medicare (Part A, Part B or both).
 - (b) The last day of the month in which the Dependent Child marries, provided such date is no earlier than the last day of the COBRA Coverage period

that would have applied to that child as a result of the death of the Covered Worker.

- (c) The last day of the calendar quarter in which the Dependent Child ceases to qualify as a Dependent of the Surviving Spouse, provided such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child as a result of the death of the Covered Worker.
 - (d) The date the Surviving Spouse's coverage under the Medicare supplemental plan terminates.
 - (e) The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.
 - (f) The effective date of any Plan amendment that results in the termination of the Dependent Child's Plan coverage.
 - (g) The date the Synod ceases to provide a group health plan to any Worker.
- (7) **Time of Coverage Termination.** If coverage terminates as of a specified day under this Section A, that coverage will terminate at 11:59 PM on such day.

B. Retired Worker Coverage

In lieu of COBRA Coverage, a Covered Worker who retires after attaining age 55 and with three years of continuous membership in the Plan may continue coverage under the Plan as a Retired Worker ("Retired Worker Coverage"). A Covered Worker who elects Retired Worker Coverage also may continue Plan Coverage for the Covered Worker's Dependents covered under the Plan when the Covered Worker retires.

- (1) **Enrollment.** To enroll for Retired Worker Coverage, a Covered Worker must submit a completed enrollment application form to the Administrator within 60 days following the date of his/her retirement.
- (2) **Required Contributions.** To obtain and retain Retired Worker Coverage under this Section B, the Retired Worker must pay required contributions to the Administrator. The Administrator will determine the amount of required contributions due for Retired Worker Coverage.
- (3) **Termination of Retired Worker Coverage for the Retired Worker.** Retired Worker Coverage for a Retired Worker under this Section B will terminate as of the earliest of the following dates.
 - (a) The date the Synod ceases to provide a group health plan to any Worker.

- (b) The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.
 - (c) The date the Retired Worker is eligible to elect Medicare coverage (Part A, Part B or both) (whether due to the attainment of a specified age or as a result of being Totally Disabled).
 - (d) The effective date of any Plan amendment that results in the termination of the Retired Worker's Retired Worker Coverage.
 - (e) The date the Retired Worker attains age 65.
- (4) **Termination of Retired Worker Coverage for Dependent.** Except as provided in subsection 6 below, termination of Retired Worker Coverage for a Retired Worker under subsection 3 above would have the effect of terminating related Dependent coverage under this Section B. In addition, coverage of a Dependent under this Section B will terminate as of the earliest of the following dates.
- (a) The date the Dependent, after Dependent coverage under this Section B is elected, becomes covered under another group health plan, including, without limitation, this Plan or Medicare (Part A, Part B or both).
 - (b) In the case of a Dependent Child, the last day of the month in which a Dependent Child marries—provided such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Covered Worker's retirement.
 - (c) The last day of the calendar quarter in which the Dependent ceases to qualify as a Dependent of the Retired Worker, provided, in the case of a Dependent Child, such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Covered Worker's retirement.
 - (d) The effective date of any Plan amendment that results in the termination of the Dependent's Plan coverage.

The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.

5. **Totally Disabled.** If a Covered Worker who has terminated employment would qualify for Retired Worker Coverage under this Section B but for the fact he/she is Totally Disabled (see subsection 3(c) above), then the Covered Worker may

continue supplemental Medicare benefits available under the WELS VEBA Group Health Care Plan Medicare supplemental plan (described under subsection 6 below), subject to the terms and conditions of that plan.

- (6) **Medicare Supplement Coverage.** When the Retired Worker is entitled to Medicare and, as a result, no longer eligible to continue Retired Worker Coverage under this Plan, the Retired Worker may continue supplemental Medicare benefits available under the Medicare supplemental plan, subject to the terms and conditions of that plan. If the Retired Worker elects supplemental Medicare benefits under the Medicare supplemental plan, a covered Dependent of the Retired Worker may continue coverage under this Plan until the earliest of the following dates:
- (a) The date the Dependent, after Retired Worker Coverage for the Dependent is elected, becomes covered under another group health plan, including, without limitation, this Plan or Medicare (Part A, Part B or both).
 - (b) In the case of a Dependent Child, the last day of the month in which the Dependent marries—provided such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Covered Worker’s retirement.
 - (c) The last day of the calendar quarter in which the Dependent ceases to qualify as a Dependent of the Retired Worker, provided, in the case of a Dependent Child, such date is no earlier than the last day of the COBRA Coverage period that would have applied to that child had COBRA Coverage been elected for that child at the time of the Covered Worker’s retirement.
 - (d) The date the Retired Worker’s coverage under the Medicare supplemental plan terminates.
 - (e) The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to such coverage.
 - (f) The effective date of any Plan amendment that results in the termination of the Dependent’s Plan coverage.
 - (g) The date the Synod ceases to provide a group health plan to any Worker.
- (7) **Time of Coverage Termination.** If coverage terminates as of a specified day under this Section A, that coverage will terminate at 11:59 PM on such day.

C. COBRA Continuation Coverage

Each person who is a Qualified Beneficiary shall have the right to elect continued coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing health coverage under the Plan. The extended coverage under this Section C is known as “COBRA Coverage.”

- (1) **Qualified Beneficiary.** A “Qualified Beneficiary” is any person who, as of the day before a Qualifying Event, is:
- (a) A Covered Worker;
 - (b) The Spouse of a Covered Worker and covered under the Plan; or
 - (c) The Dependent Child of a Covered Worker and covered under the Plan.

A Covered Worker can be a Qualified Beneficiary only if the Qualifying Event is described in subsection (2)(b). A retiree or other former Worker actively participating in the Plan by reason of a previous period of employment may be treated as a “Qualified Beneficiary.”

An individual who fails to elect COBRA Coverage within the election period provided in subsection (5) shall not be considered a Qualified Beneficiary.

- (2) **Qualifying Event.** Any of the following shall be considered a “Qualifying Event” if it would result in the loss of health benefit coverage under the Plan.
- (a) Death of the Covered Worker.
 - (b) Termination (other than by reason of gross misconduct) of the Covered Worker’s employment or a reduction of hours of employment below any minimum level of hours required for participation in this Plan. In the case of a Covered Worker who:
 - (i) does not return to covered employment at the end of an FMLA leave, the Qualifying Event of termination occurs on the earlier of the last day of the FMLA leave or the date the Covered Worker notifies his/her Employer of the intention not to return to active employment; or
 - (ii) is absent more than 31 days due to a period of duty with the Uniformed Services, the Qualifying Event occurs on the first day of such absence.
 - (c) Divorce or legal separation of the Covered Worker from the Covered Worker’s Spouse.

(d) A Covered Worker becoming eligible to receive Medicare Benefits under Title XVIII of the Social Security Act (Part A, Part B, or both).

(e) A Dependent Child of a Covered Worker ceasing to be a Dependent.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Sponsoring Organization, and that bankruptcy results in the loss of coverage of any Retired Worker covered under the Plan, the Retired Worker may be a Qualified Beneficiary with respect to the bankruptcy. The Retired Worker's Spouse, Surviving Spouse, and Dependent Children may also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(3) **Benefit Available Under COBRA Coverage.** A Qualified Beneficiary who is eligible to elect to continue coverage under this Section C shall have the right to continue the level of coverage in effect for the Covered Worker on the day before the Qualifying Event. If that coverage changes for similarly situated Covered Worker (or, in the case of a Dependent, for similarly situated covered Dependents), then coverage will change for those on COBRA Coverage. In addition, the same options given to similarly situated Covered Workers (or, in the case of a Dependent, similarly situated covered Dependents) in the case of a WELS VEBA Group Health Care Plan health benefit coverage change will be available.

(4) **Notice Requirements.**

(a) **Notice Upon Commencement of Coverage.** When a Worker becomes a Covered Worker under this Plan, the Administrator will inform the Covered Worker (and the Covered Worker's Spouse, if any) in writing of the rights to continued coverage under this Section C.

(b) **Notice of Qualifying Event.** The Plan will offer COBRA Coverage to Qualified Beneficiaries only after the Administrator has been notified that a Qualifying Event has occurred.

(i) The Covered Worker's Employer must give the Administrator written notice of a Qualifying Event described in subsection 2(a), (b), or (d) (or a Qualifying Event resulting from the Employer's filing of a bankruptcy petition) within thirty (30) days of the occurrence thereof.

(ii) Within fourteen (14) days of receipt of the Employer's notice (described in subparagraph (i)), the Administrator shall furnish each Qualified Beneficiary with written notification of the

termination of regular coverage under the Plan, as well as a recital of the rights of any such Qualified Beneficiary to elect COBRA Coverage as required by Internal Revenue Code section 4980B and section 601 of the Employee Retirement Income Security Act of 1974, in accordance with the terms of this Plan.

- (iii) In the case of a Qualifying Event described in subsection 2(c) or (e), a Covered Worker or Qualified Beneficiary who is a Spouse or Dependent of such Covered Worker must notify the Administrator in writing within sixty (60) days of the occurrence thereof. The Administrator shall give written notification of COBRA Coverage rights to any affected Qualified Beneficiary within fourteen (14) days of its receipt of the notice described in this subparagraph (iii).

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Worker is treated as notification to all other Qualified Beneficiaries residing with that Spouse at the time notification is made.

- (5) **Election Period.** A Qualified Beneficiary entitled to COBRA Coverage shall have sixty (60) days from the later of the date coverage would otherwise end or date of the notice required by subsection (4) is delivered in which to return a signed election to the Administrator indicating the choice to continue benefits under this Plan. Each Qualified Beneficiary will have an independent right to elect COBRA Coverage. Covered Workers may make COBRA Coverage elections on behalf of their Spouses, and parents may make COBRA Coverage elections on behalf of their children.

If a Qualified Beneficiary initially elects to waive COBRA Coverage, the Qualified Beneficiary may revoke that waiver election at any time during the 60-day election period. The Plan, however, will only provide COBRA Coverage beginning with the date of the revocation of the waiver election and not retroactively. This will result in a lapse of continuous coverage under the Plan.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make a COBRA Coverage election, the 60-day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

- (6) **Duration of COBRA Coverage.** Unless terminated earlier pursuant to subsection (8), COBRA Coverage will be available for the following periods, as applicable.
 - (a) **Termination of Employment/Reduction in Hours—18-Month Rule.** COBRA Coverage shall extend for a period of eighteen (18) months after the date that

regular coverage ends due to the Covered Worker's termination of employment or reduction of hours of employment to a level that disqualifies him/her from participation in the Plan.

- (i) **Extension to 29 Months—Disability.** This eighteen (18) month period is extended to twenty-nine (29) months if the Social Security Administration ("SSA") determines within the eighteen (18) month period that a Qualified Beneficiary was disabled some time before the 60th day of COBRA Coverage. To secure the extended coverage after a determination of disability, the Qualified Beneficiary must notify the Administrator of SSA's finding within sixty (60) days of its issue.

If a Qualified Beneficiary obtains 29 months of COBRA Coverage under this subparagraph (i) because a Qualified Beneficiary was disabled, the Qualified Beneficiary must notify the Administrator of any determination by the SSA that the previously disabled Qualified Beneficiary is no longer disabled. Notification to the Administrator must be made within 30 days of the date such determination is made.

- (ii) **Second Qualifying Event.** If, during the eighteen (18) month period, a subsequent Qualifying Event occurs (i.e., that would have resulted in a loss of coverage had the initial Qualifying Event not occurred), each Qualified Beneficiary (other than the Covered Worker) having COBRA Coverage shall be entitled to elect to continue coverage under the Plan for up to thirty-six (36) months following the date coverage was originally lost due to termination of employment or reduction of hours. Notice of the second Qualifying Event must be given to the Administrator for this extension to apply. In no event shall COBRA Coverage extend more than thirty-six (36) months beyond the date regular coverage would otherwise have ended as a result of the original Qualifying Event.
- (iii) **Entitlement to Medicare.** If the Covered Worker became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event of his/her termination of employment or reduction of hours, the Covered Worker's Spouse and each covered Dependent Child shall be eligible to elect to continue coverage until the date that is thirty-six (36) months from the date the Covered Worker first became so entitled. For purposes of determining COBRA Coverage rights "entitlement" means actual enrollment for Medicare benefits.

- (c) **Other Qualifying Events—36-Month Rule.** Thirty-six (36) months of COBRA Coverage shall be available to:

- (i) A Covered Worker's Spouse or Dependent Child who loses coverage under this Plan by virtue of the Spouse's divorce or legal separation from the Covered Worker;

- (ii) A Dependent Child of the Covered Worker who loses coverage by ceasing to be a Dependent;
 - (iii) Any Spouse or Dependent Child who loses coverage where the Qualifying Event is the Worker's death;
 - (iv) Any Spouse or Dependent Child where the Covered Worker's entitlement to Medicare benefits results in loss of coverage under this Plan.
- (7) **Birth or Adoption of a Child.** If through birth, adoption or placement for adoption a former Covered Worker acquires a new Dependent Child during a period of COBRA Coverage, then such child shall be treated as a Qualified Beneficiary eligible to elect COBRA Coverage for the remainder of the COBRA Coverage period to which that child would have been entitled had the child been a Dependent Child at the time of the Qualifying Event.
- (8) **Automatic Termination of COBRA Coverage.** Notwithstanding any other provision of this Section C to the contrary, COBRA Coverage shall automatically cease if any of the following events occurs.
- (a) The Synod ceases to offer a group health plan to any Worker.
 - (b) The required monthly contribution, as defined in subsection (9), for COBRA Coverage is not timely paid within the period prescribed under subsection (9).
 - (c) After electing COBRA Coverage, an electing Qualified Beneficiary becomes covered under another group health plan or eligible to receive benefits under Medicare. If the Qualified Beneficiary has a condition that is not covered under the other group health plan because the other group health plan contains a pre-existing condition limitation, then the Qualified Beneficiary may continue COBRA Coverage under the Plan for the period of time that he/she is denied coverage under the other group health Plan for the pre-existing condition, but no longer than the COBRA Coverage period for which the Qualified Beneficiary is eligible. (COBRA Coverage under the Plan will not be permitted if the other group health plan contains a pre-existing condition exclusion or limitation which does not apply to the Qualified Beneficiary by reason of the other group health plan's portability, access and renewability provision restricting the application of the pre-existing condition limitation.)
 - (d) For a Qualified Beneficiary who has extended COBRA Coverage due to SSA disability status of Qualified Beneficiary under subsection (6)(a)(i), the date on which the Qualified Beneficiary is no longer considered to be disabled by SSA (i.e., provided such date is not before the end of the

maximum COBRA Coverage period that would have applied without regard to the disability extension).

- (9) **Required Monthly Contribution.** To obtain COBRA Coverage, a Qualified Beneficiary must pay the required monthly contribution to the Administrator. The amount of the required monthly contribution shall be determined by the Administrator in accordance with Internal Revenue Code section 4980B and will not exceed 102% of the applicable premium for the period in question. If the COBRA Coverage period is extended under subsection (6)(a)(i), the Administrator may charge up to 150% of the applicable premium for the 11 additional months of coverage provided as a result of the disability.

The required monthly contribution is due as of the first day of each calendar month during which COBRA Coverage is continued under this Section C. A required monthly contribution payment shall be considered timely if it is made within thirty (30) days after the date such payment is due.

The initial required monthly contribution for COBRA Coverage shall be considered timely if made by the later of (a) the date that is forty-five (45) days after the date the Qualified Beneficiary timely elects COBRA Coverage pursuant to subsection (5) or (b) the date that is thirty (30) days after the first day of the first calendar month of COBRA Coverage. If the initial required monthly contribution is timely, as described in the preceding sentence, but is paid more than thirty (30) days after the due date of a required monthly contribution for a month of COBRA Coverage, the initial required monthly contribution shall include the required monthly contribution for that month.

RE-ENROLLMENT PROVISIONS

A. Full-time Student Re-enrollment

If a Covered Worker's Dependent Child ceases to be a full-time student and, as a result, ceases to be eligible for coverage under the Plan as a Dependent, then the Covered Worker may again enroll the child for Plan coverage when the child returns to school as a full-time student (i.e., provided the child otherwise qualifies as a Dependent).

If a Member timely and properly requests re-enrollment of a Dependent Child under this Subsection (A), coverage for the affected Dependent student will be effective on the date he/she again attends classes as a full-time student.

B. Military Service

The Plan provides benefits in compliance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). A Worker who has served in the uniformed services should contact the WELS Benefit Plans Office for additional information regarding coverage and enrollment rights.

TERMINATION OF COVERAGE

A. Worker's Termination of Coverage

Unless a Covered Worker is eligible for and elects to continue Plan coverage under an applicable provision under "CONTINUATION COVERAGE" above, the Worker's Plan coverage will terminate as of the earliest of the following dates.

1. The last day of the calendar quarter in which the Worker terminates employment.
2. The date following the end of the designated leave period if the Covered Worker is on FMLA leave and does not return to employment immediately following the designated FMLA leave period (as provided below) (or, if earlier, the date the Worker notifies his/her Employer that he/she will not return to employment).
3. The date the Worker dies.
4. The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to the Worker's Plan coverage.
5. The date the Worker withdraws from the Plan.
6. The date the Plan terminates.
7. The effective date of any Plan amendment that results in the termination of the Worker's Plan coverage.

B. Dependent's Termination of Coverage

Unless coverage for a covered Dependent is continued under an applicable provision under "CONTINUATION COVERAGE" above, the covered Dependent's Plan coverage will terminate as of the earliest of the following dates.

1. The date Plan coverage of the Covered Worker through whom the Dependent obtains Plan coverage terminates.
2. The close of the month in which the Dependent marries.
3. The last day of the calendar quarter in which he/she ceases to be a Dependent.
4. The last day of the coverage period immediately preceding the coverage period for which the Administrator does not timely receive required contributions with respect to the Dependent's Plan coverage.
5. The date the Dependent dies.
6. The date the Plan terminates.
7. The effective date of any Plan amendment that has the effect of terminating the Worker's Plan coverage.

TERMINATION OF COVERAGE

- 8.** The date the Covered Worker elects to discontinue coverage for the Dependent under the Plan, pursuant to rules and procedures established by the Administrator.

Coverage of a Dependent will not terminate under subsection 2 or subsection 3 above due to the marriage of the Dependent if, because of the marriage, the Dependent becomes the covered Dependent Spouse of a different Covered Worker.

If coverage terminates as of a specified day under Section A or Section B above, that coverage will terminate at 11:59 PM on such day.

COMPREHENSIVE MEDICAL BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Hospital Room and Board

Eligible Hospital charges are those incurred for semi-private rooms, wards, intensive care and coronary care units. Eligible charges for a private room are limited to the average semi-private room rate for the facility where confined. When the facility has private rooms only or a private room is Medically Necessary, the private room rate will be considered.

Hospital Miscellaneous Charges

Eligible charges are covered for Medically Necessary services and supplies which are provided while Hospital confined. Eligible charges are covered for visits made by a physician or medical specialist while confined in a Hospital or Skilled Nursing Facility. Personal items which are not Medically Necessary are not covered.

Outpatient Facility Services

If a Member receives care in the outpatient department of a Hospital, clinic or in an approved Ambulatory Surgical Center, eligible charges for outpatient services include, for example, the following:

1. surgery;
2. treatment of an accidental Injury;
3. treatment of a condition requiring medical care;
4. inhalation therapy, dialysis treatment, radiation, x-ray and chemotherapy; and
5. pre-admission testing.

Ambulance

Eligible charges are covered for local professional ambulance service. Transportation must be to the nearest Hospital qualified to provide treatment for the Injury or Illness. If the Injury or Illness requires special treatment which is not available in a local Hospital, transportation to the nearest Hospital equipped to provide treatment is covered.

Surgical Services

Eligible charges are covered for surgery when performed in a Hospital, outpatient department of a Hospital, Ambulatory Surgical Center or clinic. Eligible charges include Hospital pre-operative and post-operative care. Eligible charges for surgical services include, for example, the following:

1. cosmetic surgery required as a result of an accidental Injury;

2. functional repair or restoration of any body part when necessary to achieve normal body function;
3. charges for an assistant surgeon, if determined to be Medically Necessary by the Third Party Plan Administrator; and
4. charges for an elective sterilization for a Member or covered Dependent, only when determined to be Medically Necessary due to a life threatening situation to the mother or baby as determined by the Administrator.
 - When a surgeon performs two or more surgical procedures during the same operative session, the Plan will pay the primary surgeon at 100% of the Usual and Customary amount and subsequent surgeries at 50% of the usual and customary amount.
 - When a surgeon performs the same surgical procedures on both sides of the body during the same operative session, the Plan will pay 100% of the Usual and Customary amount for the first procedure and 75% for the second.
 - The surgical assistant fee provided by a physician shall be considered at 25% of the surgical allowance of the primary surgeon's fee. A physician's assistant, registered nurse first assistant, or registered nurse practitioner provides medically appropriate assistance to the surgeon, the assistant's surgical fee shall be considered at 15% of the U&C amount of the surgical procedure.

Oral Surgery

Eligible charges are covered for the following oral surgical procedures:

1. surgical exposure or extraction of impacted wisdom teeth;
2. excision of exostosis of the jaw and hard palate;
3. removal of tumors or cysts of the jaw, cheeks, tongue, or the roof or floor of the mouth, (does not include the removal of tumors or cysts related to gums and teeth);
4. gingivectomy - excision of loose gum tissue to eliminate infection;
5. apicoectomy - excision of apex of tooth root, but not to include root canals;
6. external incision and drainage of cellulitis, not including those related to gums and teeth;
7. treatment of accidental Injuries to natural teeth including replacement of such natural teeth. However, treatment must be rendered within 72 hours of the accidental Injury and treatment must be completed 12 months from the date of the Injury
8. incision of accessory sinuses, salivary glands or ducts;
9. alveolectomy - the leveling of structures supporting teeth for the purpose of fitting dentures;
10. frenectomy, the cutting of the tissue in the tongue's midline in order to alleviate tongue-tie;

11. osseous surgery;
12. treatment of facial and jaw fractures;
13. surgery related to temporomandibular joint dysfunction; and
14. osteotomies, with or without LaForte. Only with prior authorization.

Anesthesia

Eligible charges are covered for anesthesia and its administration when rendered by a provider who is licensed to perform these services. When anesthesia services are performed by a certified nurse anesthetist (CNA) under the direction of a physician, the Plan shall reimburse the certified nurse anesthetist (CNA) based on the percentage of the Usual and Customary charges for the physician.

Other Covered Treatment, Services and Supplies

Eligible charges are covered for the following:

1. examinations when rendered for the diagnosis and treatment of an Illness or Injury;
2. diagnostic x-ray, laboratory, and related radiology and pathology services when rendered for the diagnosis and treatment of an Illness or Injury;
3. blood or blood plasma, other than the Member's or that which has been donated specifically for the Member;
4. initial purchase of prosthetic devices and supplies, including artificial limbs or eyes which replace an absent or malfunctioning body part or organ. Replacements thereof are covered if approved by CMS;
5. casts, splints, orthopedic braces, jobst stockings (2 pair per Calendar Year) and crutches;
6. charges for compound prescriptions when purchased through a wholesale pharmacy vendor;
7. treatment to sound natural teeth due to an accidental Injury, other than those caused by chewing food or similar substances. The Member must receive medical care within 72 hours of the accident. The member may receive care for up to 12 months from the date of the Accident;
8. special supplies when prescribed by the attending physician such as:
 - catheters;
 - colostomy bags, rings and belts;
 - flotation pads;
 - medical supplies, drugs and medicines prescribed by the attending physician, if necessary under the Home Health Care Plan, but only to the extent such items would have been provided under the Plan had the Member been hospitalized; and

- one insulin infusion pump each Calendar Year if the Member has used that pump for a minimum of 30 days. Requires prior authorization.
9. rental (not to exceed purchase price) or purchase of durable medical equipment, such as wheelchairs, Hospital-type beds, iron lung, oxygen equipment (including oxygen) and other durable medical equipment. Durable medical equipment is equipment which:
- can withstand repeated use;
 - is primarily and customarily used to serve a medical purpose; and
 - generally is not useful to a Member in the absence of an Illness or Injury.

Eligible charges for medical equipment which is prescribed by a physician will be covered while the Member is receiving medical care. Eligible charges are limited to the least expensive item which is adequate for the Member's needs. **Prior authorization is required for all durable medical equipment over \$750.** Repairs are covered when needed to restore proper function. Repairs and replacements are covered as specified on the Schedule of Benefits;

10. services and supplies which are cosmetic and are required as a result of an accidental Injury. Treatment needed to achieve bodily function is covered;
11. injections of medication related to a covered Illness or Injury;
12. charges for eligible prescription drugs only when Medicaid is primary;
13. treatment of temporomandibular joint dysfunction (office visits, lab, arthrogram, panoramic film and cephalometric films, physical therapy, biofeedback treatment and surgical treatment);
14. Hospital, surgical and other necessary medical charges, including rental of kidney dialysis equipment incurred for kidney dialysis treatment;
15. charges or taxes legally imposed by a governmental entity including those calculated on the amount of eligible charges paid for a Member under the Plan; and
16. charges for and related to a mastectomy, including:
- a) reconstruction of the breast on which the mastectomy has been performed;
 - b) surgery and reconstruction of the other breast to produce a symmetrical appearance when performed in connection with a mastectomy; and
 - c) prosthesis and physical complications of all stages of a mastectomy, including lymphedemas.

Note: The Plan will cover two prosthetic bras per year after a mastectomy. The second bra is not considered under repair/replacement DME.

MISCELLANEOUS BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Inpatient, Outpatient, Partial and Intense Treatment of Mental Health and Substance Abuse

Eligible charges for inpatient, outpatient, partial and intense treatment for Mental Health and Substance Abuse are covered as specified on the Schedule of Benefits. Treatment must be rendered in a facility licensed in the state in which it is located.

Outpatient services include partial Hospitalization privileges and collateral interviews with the family of the Member receiving treatment. Treatment must be related to the diagnosed condition.

A partial and intense treatment program is a non-residential program which provides case management, counseling, medical care and psychotherapy on a regular basis for a scheduled part of a day and a scheduled number of days per week. In a partial and intense treatment program, services are rendered in a less restrictive manner than inpatient services but in a more intensive manner than are outpatient services.

Residential treatment is not a covered service.

Skilled Nursing Facility

Eligible charges for care rendered in a licensed Skilled Nursing Facility are covered as specified on the Schedule of Benefits. The Member must enter a licensed Skilled Nursing Facility within 24-hours after discharge from a Hospital Confinement or a related Confinement in a Skilled Nursing Facility. Care must be Medically Necessary as certified by the attending physician every seven days and must be for the same condition as treated in the Hospital or previous Skilled Nursing Facility. The daily rate will not exceed the rate established for such care by the Department of Health and Human Services.

Home Health Care

Eligible charges for Home Health Care are covered as specified on the Schedule of Benefits and are those charged by a Home Health Care agency for:

1. evaluation of the need for, and development of, a Plan by a registered nurse or medical social worker when approved or requested by the attending physician;
2. part-time or intermittent home nursing care rendered by or under the supervision of, a registered nurse;
3. part-time or intermittent services of home health aides which are:
 - (a) Medically Necessary as part of the Home Health Care Plan;
 - (b) under the supervision of a registered nurse or medical social Worker; and

(c) which consist solely of caring for the Member;

Each visit by a provider of Home Health Care of four hours or less is considered one visit.

Limitations

Home Health Care services do not include:

1. services or supplies not included in the Home Health Care Plan;
2. services of a Family Member;
3. Custodial Care;
4. food, housing, homemaker services or home delivered meals; or
5. transportation services.

Hospice Care

If a physician certifies that a Member is terminally ill, eligible charges for Medicare certified hospice care are covered. Hospice care emphasizes the management of pain and other symptoms associated with terminal illness. A Member is considered to be terminally ill if his or her medical prognosis is a life expectancy of six months or less.

Chiropractic Care

Eligible charges for chiropractic care including one initial exam, spinal or cervical x-rays, manipulations and supportive care are covered as specified on the Schedule of Benefits. Supportive care means treatment which is Medically Necessary to prevent the Member's condition from significantly deteriorating. Maintenance care is routine and is not Medically Necessary for treatment of a condition. Maintenance care and non-manipulative therapy are not covered by the Plan.

Therapy Services (Physical, Speech and Occupational)

Eligible charges for physical, speech and occupational therapy are covered as specified on the Schedule of Benefits. Speech therapy is covered only when the therapy is Medically Necessary due to an accidental injury, surgery or organic pathological disorder such as a stroke. Speech therapy is not a covered benefit for development delay.

Repair/Replacement of Durable Medical Equipment

Eligible charges for the repair or replacement of durable medical equipment is covered as specified on the Schedule of Benefits. Preauthorization is required prior to a repair or the replacement of an item. Replacements thereof are covered if approved by CMS. Repairs are covered when needed to restore proper function. Prior Authorization is required for any repair/replacement.

Orthoptic/Vision Therapy

Eligible charges for orthoptic/vision therapy are covered as specified on the Schedule of Benefits.

MISCELLANEOUS BENEFITS

Medicaid Prescription Drugs

Eligible charges for prescription drugs are covered as specified on the Schedule of Benefits.

Note: This benefit applies to eligible prescription drugs **only** when submitted by Medicaid. For all other prescription drugs please refer to the Prescription Drug Benefit section of the Plan.

Routine Vision Care

Eligible charges for routine vision care, including examinations, frames, lenses and contacts are covered as specified on the Schedule of Benefits.

Wellness Benefit

Eligible charges for routine care, including examinations, pap smears, mammograms, other related x-ray and laboratory services, immunizations and well-baby care are covered as specified on the Schedule of Benefits.

Maternity/Newborn Infant Charges

Eligible charges are covered as specified on the Schedule of Benefits for medical care in connection with pregnancy, childbirth or a related medical condition of a Member. This includes charges for (3) three ultrasounds per pregnancy. Eligible inpatient charges for the healthy newborn infant are covered under the covered mother's plan of benefits. Thereafter, eligible charges for the newborn are covered under the covered newborn's plan of benefits. If the mother is not covered under the Plan or if the newborn infant is born unhealthy, eligible charges will be covered under the covered newborn's plan of benefits. Eligible charges for inpatient care of a newborn infant of the Member include, for example, the following:

:

1. Hospital nursery room, board and care;
2. necessary x-ray and laboratory services;
3. physician's visits;
4. charges for circumcision;
5. treatment for premature birth; and
6. necessary surgery to repair or restore a body part to achieve normal function.

For purposes of this section regarding Maternity/Newborn Infant Charges, the term "Hospital" includes a Birthing Center.

Infertility Treatment

Eligible charges for infertility treatment (exams, laboratory, x-ray and diagnostic procedures) are covered as specified on the Schedule of Benefits. Treatment does not include: in-vitro fertilization and related services, artificial insemination, reversion of surgically induced infertility, or surrogate maternity benefits.

Sleep Studies

Eligible charges for sleep studies are covered as specified on the Schedule of Benefits.

Nutritional Counseling

Eligible charges for nutritional counseling are covered as specified on the Schedule of Benefits. Certain conditions such as high cholesterol / dyslipidemia, adult and pediatric weight management, hypertension, diabetes, gestational diabetes, renal insufficiency, esophageal reflux, or failure to thrive (adult and pediatric) are just some of the medical conditions nutritional counseling are used for. Services must be Medically Necessary.

Biofeedback Treatment

Eligible charges for biofeedback are covered as specified on the Schedule of Benefits.

Human Organ and Tissue Transplant

Eligible charges are covered as specified on the Schedule of Benefits for human organ and tissue transplants if the transplant procedure is not Experimental or Investigational. When a donor or recipient is involved, charges are covered as follows:

1. when both the recipient and the donor are covered by the Plan, each is entitled to benefits under the Plan.
2. when only the recipient is covered by the Plan, the Member who is the recipient is entitled to the benefits under the Plan and the donor is entitled to certain limited benefits as specified by the Plan. In this instance, for the donor, only those eligible charges for services to donate the human organ or tissue will be covered. The donor will be eligible for these specified benefits under the Plan only if such charges are not covered for the donor from any other source, including for example, any insurance coverage, worker benefit plan or government program. Eligible donor charges covered by the Plan will accumulate toward any maximum applicable to the Member who is the recipient; or
3. when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan as specified on the Schedule of Benefits. However, any other source of coverage available to the donor will be considered the primary payor of benefits and this Plan will be the secondary payor of benefits. No benefits are provided to the non-covered transplant recipient.

Eligible charges related to an organ or tissue transplant include for example hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility and those related to the evaluation and/or procurement of the organ or tissue. Benefits will not be duplicated if they are available from another Plan, an organization or Medicare.

Specified Transplant Covered Expenses

The specified transplant benefit shall apply to national BlueCard facilities in addition to any Administrator contracted transplant facilities within the state of Wisconsin.

Covered expenses, as specified in the *Human Organ and Tissue Transplant* benefit provision as provided in the Schedule of Benefits, include the following, provided: (a) the transplant is incurred while covered for this benefit; (b) the transplant is incurred at a national BlueCard facility or an Administrator contracted transplant facility located in the state of Wisconsin; and (c) the expense is incurred during a Transplant Benefit Period.

1. Facility and professional charges for assessment/evaluation and transplant related care prior to transplantation.
2. Transplantation services for a Specified Transplant.
3. Retransplantation services.
4. Facility and professional charges for services rendered after inpatient discharge from the facility.

Please note: Charges incurred by the donor with a Non-PPO provider will not be covered. Eligible donor charges may be covered only when a designated transplant center and/or PPO Hospital are utilized.

Travel Benefit

Associated travel expenses related to a Specified Transplant will be reimbursed by the Administrator when the Member receiving the transplant resides more than fifty (50) miles from the transplant site.

This includes:

1. commercial transportation to and from the site of the transplant for the Member receiving the transplant and one companion; and
2. reasonable and customary lodging and meal costs incurred by the Member and one companion. Reasonable and customary lodging and meal costs are limited to **\$200.00** per day for both the Member and one companion.

Transportation, lodging and meal costs are limited to an aggregate maximum of **\$10,000.00** per Transplant Benefit Period for both the Member and one (1) companion. Although this travel companion benefit does not affect the lifetime Maximum Benefit under the Plan, benefits may be taxable income to the Member. Please consult your tax advisor.

Definitions as used in the Specified Transplant Covered Expenses and Travel Benefit shall have the following meanings:

Retransplantation Services: Means inpatient care for a retransplantation of the same organ/tissue type performed within one year of the date of the initial transplant procedure.

Specified Transplant: Means any human to human organ or tissue transplant which is: a) otherwise covered under the Plan; and b) a covered transplant at the chosen Specified Facility. A list of covered transplants performed at each facility may be obtained from the Plan Administrator.

Transplant Benefit Period: Means a continuous period of 370 days beginning five (5) days prior to the transplant procedure and ending 365 days after the transplant procedure. For purposes of determining Transplant Benefit Period, retransplants occurring within 10

days after discharge from the initial transplant will be treated as if it were the initial transplantation.

Specified Facility: Means a medical facility that, at the time of the Member's inpatient admission for the transplant, is a participating national BlueCard facility or is an Administrator-contracted, transplant facility within the state of Wisconsin. A current list of participating transplant facilities may be obtained from the Plan Administrator.

General Provisions

It is the choice of the Member whether or not to use a Specified Facility. The Plan, Plan Sponsor, and Third Party Administrator make no representations or warranties regarding the qualifications or the quality of care provided by any provider, including those facilities that are Specified Facilities or the providers who provide services in them. Members should make their own decisions concerning the qualifications of the providers and facilities they select to provide them with medical services or supplies.

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

The following charges are not covered by the Plan. No medical benefits will be paid with respect to them, except as specified:

1. those due to an Illness or Injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
2. claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the Member is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not;
3. charges or expenses for which the Member (or the Member's parent or guardian in the instance of a minor Dependent) is not legally bound or obligated to pay or which are for medical care furnished without charge, paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government. This limitation will not apply where specifically prohibited by applicable statute;
4. those made by a Veteran's Administration Hospital or a Hospital operated by one of the Uniformed Services for a service related condition;
5. those made by a person, Hospital, or entity normally making no charge for medical care, regardless of the patient's financial ability, if the patient has no insurance for medical care. This limitation will not apply where specifically prohibited by applicable statutes;
6. those made for routine eye care, eyeglasses, contact lenses, or charges for the fitting of eyeglasses or contact lenses, unless specified otherwise by the Plan, other than the initial purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery, radial keratotomy or any surgical variation which is performed for the sole purpose of correcting nearsightedness or far-sightedness, night vision appliances;
7. routine hearing checks, hearing aids or hearing aids and related services;
8. those made for personal comfort items including television and telephone;
9. charges for dental services, unless otherwise specified by the Plan;
10. charges for night splints, orthodontic therapy and oral equilibration therapy for all conditions including temporomandibular joint dysfunction;
11. charges in excess of the "Usual and Customary" fee as specified in the General Terms and Definitions and General Information sections of the Plan;
12. charges for services not Medically Necessary for diagnosis and treatment of an Illness or Injury;
13. services, supplies, human organ and tissue transplants, prescription drugs or medications which are Experimental or Investigational;
14. travel for health;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

15. custodial care and rest cures;
16. treatment of an Illness or Injury resulting from the commission of, or attempt to commit by the Member, a felony or aggravated battery, unless the Injury or Illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or a Mental Health condition);
17. charges in connection with cosmetic surgery or treatment, including injections of varicose veins, for which the primary purpose is to enhance or alter appearance, except those charges related to an accidental Injury or charges for functional repair or restoration of any body part when necessary to achieve normal body function;
18. personal hygiene and convenience items;
19. charges incurred before the effective date or after the termination date of a Member's coverage;
20. failure to keep a scheduled visit, telephone or internet consultations charged by a provider, completion of claim forms or return to work or school forms;
21. services rendered by a Family Member, or provided by a person who resides in the home of the Member;
22. charges received by the Plan more than 12 months after the date of service;
23. purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers, breast pumps, heel lifts, batteries for any use, or garage door openers;
24. treatment of infertility and fertility enhancements, including in vitro fertilization, artificial insemination or any other artificial means of conception, transsexual surgery or treatment, and treatment of sexual dysfunction not related to organic disease, and charges for a surrogate mother. Procedures designed to reverse elective or Medically Necessary sterilizations are not covered;
25. charges made by a Hospital for a private room, unless otherwise specified by the Plan;
26. charges for smoking cessation, including deterrents;
27. charges for alternative treatment or holistic medicine;
28. charges for treatment of temporomandibular joint dysfunction (TMJ), unless specified otherwise by the Plan;
29. charges for a grandchild of the Worker, unless the grandchild meets the definition of a Dependent specified in the Plan;
30. charges in excess of any Maximum Benefit amounts specified on the Schedule of Benefits;
31. services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group if such department is maintained to provide services primarily for the benefit of the employees of such employer or the members of such association, union, trust, etc;

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

32. charges for treatment to induce weight loss, unless it is determined to be Medically Necessary for treatment of morbid obesity;
33. charges for and nutritional supplements, unless the supplements are Medically Necessary as the only source of nutrition;
34. charges for an elective abortion;
35. vasectomies and sterilizations, unless Medically Necessary due to a life threatening situation to the mother or baby as determined by the Administrator;
36. charges for the birth of a child in a home delivery setting. Charges for pre-natal and post natal care will be covered if performed by a certified nurse mid wife or an M.D.;
37. contraceptive medications and devices;
38. charges for OB risk assessments (H1001 and X5494);
39. massage therapy;
40. charges for dental implantology;
41. charges for wigs or hair prosthesis;
42. charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;
43. charges for prescription drugs, medications or supplies except those which are administered in or dispensed at a physician's office, a Hospital, Skilled Nursing Facility or other inpatient setting. This exclusion does not apply to those eligible prescription drugs in which Medicaid covers as primary;
44. charges for vocational training, including work hardening programs;
45. charges for orthotics, castings for shoe orthotics and related services;
46. charges for corrective shoes (unless an integral part of a brace or for diabetic conditions);
47. charges for weak, strained, unstable or flat feet or any tarsalgia or metatarsalgia (except for operations which involve the exposure of bones, tendons or ligaments), toe nails other than removal of nail matrix or root, and superficial lesions of the feet such as corns, calluses or hyperkeratoses;
48. charges for home sleep studies;
49. charges by a provider or facility for Pre-admission Certification or Concurrent Stay Review;
50. charges for medical records fees;
51. charges for third party examinations and treatments, such as those requested for employment, or purchase of insurance;
52. charges for examinations and all related services which are performed pursuant to state statute or regulation, unless the Injury or Illness results from an act of domestic

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

- violence or medical condition (which includes both a physical condition and/or a Mental Health condition);
- 53.** charges incurred for private duty nursing services, other than those performed for Home Health Care services;
 - 54.** charges for acupuncture;
 - 55.** a response for information may be required by the Plan in order to process claims. The Plan has the right to deny claims submitted for benefit payment if such information is not received. (Please contact the Third Party Administrator if you have questions regarding the required information);
 - 56.** any charge that is not a covered expense under the Plan;
 - 57.** charges for services not provided by a Physician/Provider are not covered under the Plan;
 - 58.** prosthetic devices and durable medical equipment which do not meet the requirements of items 1 through 4 in the definition “Medically Necessary” in the General Terms and Definitions section of the Plan; or
 - 59.** charges for services from providers who have been flagged in the BlueCard system for potential billing irregularities.

PRESCRIPTION DRUG BENEFITS

WHP Health Initiatives, Inc. will administer the Prescription Drug Plan. All prescription drug claims should be submitted directly to WHP Health Initiatives, Inc. for reimbursement.

Under this benefit, the Member is responsible for the co-payment as specified on the Schedule of Benefits. After satisfaction of the listed co-payment, eligible charges are covered at 100%.

For additional information regarding your prescription drug program, including a listing of eligible and ineligible drugs, please contact the customer service department at WHP Health Initiatives at the number listed below.

The prescription drug benefit applies if the Member has the prescription filled by a participating pharmacy. If the Member is unable to locate a participating pharmacy, the prescription along with a completed claim form, should be submitted directly to WHP Health Initiatives, Inc. at the following address:

**WHP Health Initiatives, Inc.
2275 Half Day Road STE 250
Bannockburn, IL 60015
(800) 207-2568**

COORDINATION OF BENEFITS

The Coordination of Benefits section is intended to determine which Plan provides benefits when there are two or more Plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, “plan” means any plan providing **high deductible** medical or dental benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, Employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs; (e) individual automobile “no-fault” and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; (l) employer-sponsored group medical benefit plan (whether insured or self-funded); and (m) this Plan.

The term “plan” is construed separately with respect to each plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such plan, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

“**Allowable Expense**” means any Usual and Customary fee, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

“**Claim Determination Period**” means Calendar Year, except that if in any Calendar Year the person is not covered under the Plan for the full Calendar Year, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

“**Claim**” means a request that benefits of a plan be provided or paid.

“**Primary Plan**” means a plan whose benefits are payable first according to the Order of Benefit Determination rules.

“**Secondary Plan**” means a plan which is not a Primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another plan and may be reduced because of the other plan's benefits.

For purposes of this Coordination of Benefits section, “This Plan” means the **WELS VEBA** Group Health Care Plan.

Effect on Benefits

Maintenance of Benefits: when a claim is made, the Primary plan pays its benefits without regard to any other plan. The Secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expense. No plan pays more than it would without the coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other plan does not have Coordination of Benefits, that plan pays first.
2. The benefits of a plan which covers the person as an employee, worker, or subscriber (i.e., other than as a dependent) are determined before the benefits of a plan which covers the person as a dependent.
3. The benefits of a plan which covers the person as a dependent are determined according to which parent's birthdate occurs first in a Calendar Year (day and month). If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined first. If the other plan does not contain the birthday rule but has a rule which coordinates benefits based on gender and the plans do not agree on the Order of Benefits, the rule in the other plan will determine the Order of Benefits.

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

- when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be the Primary Plan;
 - when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody are determined before the benefits of the plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent are determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and
 - notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a dependent child.
4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a plan which covers the person as a laid-off or retired employee, or as a dependent of such person, are determined after the benefits of a plan which covers

COORDINATION OF BENEFITS

such person through his or her own present employment or through the present employment of another person.

5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a plan which has covered the person for the longer period of time are determined before the benefits of a plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the Member's consent, will release to, or obtain from, any insurance company, organization or person, information needed to implement this provision. The Member shall agree to furnish any information required to apply these provisions.

Facility of Payment

Payment made under any other plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

Coordination Under the Bluecard Program

Benefits processed under the Bluecard Program may be paid prior to determining the Plan's liability for any claim(s). If it is determined that this Plan is the Secondary Plan, then this Plan shall have the right to recover the expenses paid in excess of this Plan's liability as the Secondary Plan. The participant may be required to furnish information and to take such other action as is necessary to assure the rights of this Plan.

HOW TO FILE A CLAIM

The Covered Worker and his/her covered Spouse will receive a group benefits identification card. It will provide information such as the Covered Worker's name, group name and group number.

If a network provider is utilized, the network provider will file an itemized claim for the Member and payment will be made directly to the provider.

Whenever a Member accesses health care services outside the network area, an itemized claim for those services may be filed by the provider and payment will generally be made directly to the provider, however, the host or local Plan directs CMS on whether the claim can be paid directly to the provider, or if payment should be directed to you. CMS cannot override their direction.

If claim submission is not offered by the provider of service, then the covered Member should refer to their identification card regarding the network(s) listed and ask the provider of service for the address of the network location for which the itemized claim can be submitted for processing. If the provider of service can not provide the network location address, then the Member should contact the Administrator for network address information. Payment will be made directly to the provider, and only to the Covered Worker if proof of full payment is submitted, however, as noted above, if a claim is incurred outside the network area, the host or local Plan directs CMS on whether the claim can be paid directly to the provider, or if payment should be directed to you. CMS cannot override this direction. The Member should not submit the provider's claim directly to CMS.

The Member may choose any provider of service. There is no restriction on the selection of a provider as long as the provider of service meets the definitions contained in the Plan. Benefits are payable directly to the provider of service and only to the Worker if proof of full payment is submitted, subject to the host or local plan direction noted above. If CMS needs more information to process a claim, the Member or the host or local plan will be contacted. CMS is prohibited (by Blue Cross Blue Shield Association rules), from contacting the provider of service directly.

An "itemized claim" must be submitted when filing a claim. An "itemized claim" is one which shows:

1. Covered Worker's name, address and identification number.
2. Dependent's name, if the claim is on a Dependent.
3. The Plan name.
4. Name and address of the provider of service.
5. Diagnosis.
6. Itemization of charges.
7. Date the Illness or Injury began or the date treatment started.

HOW TO FILE A CLAIM

Canceled checks, cash register receipts or personally prepared claims are not accepted in lieu of itemized claims from providers of service.

If benefits are subject to the Coordination of Benefits provision, whereby another plan is required to pay benefits first, a copy of the other plan's explanation of benefits should be sent to CMS. This can be done either when initially submitting the claim or as soon as possible thereafter. This procedure will expedite the processing of claims subject to the Coordination of Benefits provision.

GENERAL TERMS AND DEFINITIONS

ACTIVELY AT WORK” or “ACTIVE WORK” means that the Worker is at work and performing the regular duties of the Worker's position for his/her Employer.

A Worker is considered to be Actively at Work for the Employer on: (a) each day of regular paid vacation; (b) each regular non-working day, provided in each instance that the Worker was actively at work on the last regular work day preceding the absence; (c) any day a Worker is covered under the Plan by virtue of a leave as described in the Plan (other than a FMLA leave); (d) any day a Worker is on an FMLA leave; or (e) for purposes of determining a Worker's Date of Employment, any day on which a Worker is absent from employment with the Employer due to a health factor of the Worker.

“AFFILIATED AGENCIES” mean organizations under the supervision of Member Congregations, or any other Lutheran organization in fellowship with the Synod, including Northwestern Publishing House, Wisconsin Lutheran Child and Family Service, Synodical Schools, area Lutheran high schools and charitable agencies, ELS -- Evangelical Lutheran Synod, all as set forth in the Synod Yearbook. The VEBA Commission determines eligibility for participation in the Plan.

“AMBULATORY SURGICAL CENTER” means a licensed facility that provides general surgery and meets all of the following requirements:

1. is directed by a staff of physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period;
2. has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period;
3. extends surgical staff privileges to physicians who practice surgery;
4. has at least two operating rooms and one recovery room;
5. provides, or coordinates with a medical facility in the area for, diagnostic x-ray and laboratory services needed in connection with surgery;
6. provides in the operating and recovery rooms full-time skilled nursing services directed by a registered nurse; and
7. is equipped and has trained staff to handle medical emergencies. It must have a: (a) physician trained in cardiopulmonary resuscitation; (b) defibrillator; (c) tracheotomy set; and (d) blood volume expander.

“BIRTHING CENTER” means a facility meeting all criteria as an alternative to Hospital Confinement and is licensed by the state in which it is located as a birthing facility.

“BLUECARD PROGRAM” means the national program comprised of Blue Cross and Blue Shield Plans which allow a Member to receive covered services from providers who have a contract or agreement with another Blue Cross and/or Blue Shield Plan located outside the

GENERAL TERMS AND DEFINITIONS

geographical area served by CMS. The local Blue Cross and/or Blue Shield Plan which services the geographical area where the covered service is provided is referred to as the Host Blue Cross and/or Blue Shield Plan.

“CALENDAR YEAR” means the period from January 1 through December 31 of the same year.

“CERTIFICATE OF CREDITABLE COVERAGE” means a written document that discloses the Worker’s and Dependent’s Creditable Coverage under a group health plan or health insurance.

“COBRA COVERAGE” means coverage offered to comply with the requirements of section 4980B of the Internal Revenue Code and section 601 of the Employee Retirement Income Security Act of 1974 and described under Section C of the Article of the Plan titled **“CONTINUATION COVERAGE.”**

“CONFINEMENT” means the period of time in which a Member is registered as an inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

“COVERED WORKER” means a Worker who is enrolled in and covered by the Plan.

“CREDITABLE COVERAGE” means coverage under a health plan as defined in 29 CFR §2590.701-4(a).

“CUSTODIAL CARE” means care designed to help a person in the activities of daily living, and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision of medication that can be self-administered and assistance in getting in or out of bed, walking, bathing, dressing and eating.

“DATE OF EMPLOYMENT” means the date:

- The Worker is hired or called by an Employer, is available to provide service and reports to Active Work.
- If the Worker is a student who is covered by this Plan, Date of Employment means the end of the quarter in which the student is no longer a Dependent. If the Worker is a student covered by another health plan, Date of Employment means the day the student loses dependent status under that plan.

“DEDUCTIBLE OPTION” means the annual deductible limit selected by the Member. The Plan offers the following Deductible Options:

- ***High Deductible Option:*** Individual Deductible Limit—\$1,800 per person per Calendar Year, with the deductible per family limited to \$2,000 per family per Calendar Year.

GENERAL TERMS AND DEFINITIONS

“**DEPENDENT**” means each of the following individuals:

- A. The Spouse of a Worker.
- B. The child of a Worker [including the Worker’s natural child, adopted child (i.e., effective as of the date of adoption or, if earlier, the date the child is placed for adoption with the Worker), or stepchild), provided the Worker provides more than one-half the financial support of the child, the child has never married, and one of the following conditions is satisfied:
 1. The child is under age 19 and is the Worker’s dependent for federal income tax purposes or due to a court order or divorce decree.
 2. The child:
 - a) has attained age 19 but has not attained age 26; and
 - b) is attending and is earning credits as a full-time student in an educational institution. (The institution determines full-time status, except that an individual on a medical leave or other leave shall not be considered a full-time student.)
 3. The Worker provides more than one-half of the financial support for the child because the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and:
 - a) the condition began before the child would otherwise lose Dependent status under the Plan; and
 - b) the child has been continuously covered by the Plan.
- C. The child of a Dependent for the period of time that the Worker provides more than one-half the financial support of the child **and** the child is the Worker’s dependent for federal income tax purposes.

For purposes of this Plan, the term “Dependent Child” means a Dependent of a Worker described in B or C above.

“**EFFECTIVE DATE OF THE PLAN**” means the effective date of this restatement of the Plan, which is January 1, 2005.

“**EMPLOYER**” means the Sponsoring Organization that employs the Worker.

“**EXPERIMENTAL OR INVESTIGATIONAL**” means any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. the device, drug or medicine 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 device, drug or medicine is furnished;

GENERAL TERMS AND DEFINITIONS

2. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis;
3. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means 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 treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigational shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of non-human organs, tissues, or cells.

“FAMILY MEMBER” means a Member's Spouse, child, parent, brother, sister and any other eligible Dependent as described by the Plan.

“HOME HEALTH CARE” means services or supplies rendered to, and in the home of, a Member or in the home of a Family Member as an alternative to services and supplies provided as part of an inpatient Confinement in a Hospital or Skilled Nursing Facility.

“HOME HEALTH AIDE SERVICES” means those services which may be provided by a qualified individual, other than a registered nurse, which are Medically Necessary for the care and treatment of a Member.

“HOME HEALTH CARE AGENCY” means an agency which: (a) is certified by the Member's physician as an appropriate provider of Home Health Aide Services; (b) has a full-time Administrator; (c) maintains daily clinical records of services provided to the Member; (d) includes on its staff at least one registered nurse to supervise nursing care; and (e) is coordinated by a state licensed Medicare certified Home Health Care agency or certified rehabilitation agency.

“HOME HEALTH CARE PLAN” means care and treatment of a Member for an Injury or Illness under a Plan of home care established and approved in writing by the Member's attending physician. The physician must also certify that the treatment for the Injury or Illness would otherwise require Confinement in a Hospital or a Skilled Nursing Facility. The Home Health Care Plan must be reviewed at least every two months.

“HOSPITAL” means an institution which is duly licensed as a Hospital (to the extent such licensing is required by state or federal law) and which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and which meets all of the following requirements:

GENERAL TERMS AND DEFINITIONS

1. is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a Hospital that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;
2. provides organized facilities for laboratory, diagnostic services, medical treatment and surgery;
3. provides 24-hour nursing care by licensed registered nurses;
4. has a staff of one or more licensed physicians available at all times; and
5. in no event, however, shall the term Hospital include an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility or a home for the aged.

“ILLNESS” means pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

“INJURY” means a condition caused by accidental means and from an external force which results in damage to the Member's body from an external force.

“INTENSIVE CARE UNIT OR CORONARY CARE UNIT” means a section, ward, or wing within a Hospital, which is operated solely for critically ill patients. It provides special supplies, equipment and constant observation and care by registered nurses or other Hospital personnel.

“LOSS OF ELIGIBILITY” means a “Loss of Eligibility” as defined in 29 CFR §2590.701-6(a)(3)(i) and includes a situation in which an individual is no longer eligible for coverage under the health Plan due to divorce, legal separation, death, loss of Dependent status, termination of employment or reduction of hours, or reaching the lifetime cap on benefits. The decision not to continue paying premiums under the other health Plan or termination of coverage for cause is not considered a Loss of Eligibility.

“MASTER PLAN DOCUMENT” means that document signed by the Plan Sponsor and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto which set forth the terms of the Plan.

“MAXIMUM BENEFIT” means the total eligible charges that the Plan will pay per Member while that Member is covered by the Plan.

“MEDICALLY NECESSARY” means that a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care provider is required to diagnose or treat a Member's Illness or Injury and which is, as determined by the Third Party Administrator: (1) consistent with the symptoms or diagnosis and treatment of the Member's Illness or Injury; (2) appropriate under the standards of acceptable medical practice to treat that Illness or Injury; (3) not solely for the convenience of the Member, physician, Hospital or other health care provider; and (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Member and accomplishes the desired

GENERAL TERMS AND DEFINITIONS

end result in the most economical manner. However, the fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply Medically Necessary.

“MEDICARE” means the program for health benefits under Title XVIII of the Social Security Act as amended.

“MEMBER” means:

- A. The Covered Worker;
- B. The Covered Worker’s Dependents when enrolled and covered for health benefits under the Plan;
- C. An individual covered under one of the following articles of the Plan:
 1. Leave of Absence
 2. Totally Disabled
 3. Continuation Coverage

The term “Member” shall include the individuals identified in the definition of Member unless otherwise indicated.

“MEMBER CONGREGATIONS” means the individual congregations listed in the “directory of congregations” in the annual Synod Yearbook.

“MENTAL HEALTH” means mental, nervous or emotional disease or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

“PHYSICIAN/PROVIDER” means any person who is validly licensed to perform services for which benefits are provided under the Plan and who is acting within the scope of that license. For purposes of Mental Health and Substance Abuse charges, “Physician/Provider” shall also include any person approved or licensed by the state in which services are rendered for treatment of such conditions.

“PLAN” means group health Basic Plan Option under the WELS VEBA Group Health Care Plan, as set forth in this Master Plan Document (including all its schedules, provisions, exclusions, limitations, and appendices), as amended from time to time.

“PLAN ADMINISTRATOR” or “ADMINISTRATOR” means the VEBA Commission, which is responsible for administering the Plan, as provided in the “VEBA Commission and Plan Administration” section. The WELS Benefit Plans Office provides services on behalf of the Administrator.

GENERAL TERMS AND DEFINITIONS

PLAN OPTION” means the Plan health benefit coverage option selected by the Covered Worker. The Plan offers the following Plan Options:

- a) *Employee Only Coverage*—under which the Plan covers only the Covered Worker.
- b) *Employee plus Spouse Coverage*—under which the Plan covers only the Covered Worker and the Covered Worker’s Spouse.
- c) *Employee plus Non-Spouse Dependent Coverage*—under which the Plan covers the Covered Worker and the non-Spouse Dependents of the Covered Worker, but does not cover the Spouse of the Covered Worker.
- d) *Family Coverage*—under which the Plan covers the Covered Worker and all of the Covered Worker’s Dependents.

PLAN SPONSOR” means the Wisconsin Evangelical Lutheran Synod.

“PLAN YEAR” means the 12-month period beginning January 1st and ending December 31st.

“QUALIFIED MEDICAL CHILD SUPPORT ORDER” means any judgment, decree or order, including approval of a settlement agreement, issued by a court that:

- a) Provides for child support or health benefit coverage with respect to a child of a Member, is made pursuant to a state domestic relations law (including community property law) and relates to benefits under the Plan; or
- b) Enforces a law relating to medical child support with respect to a group health Plan described in section 1908 of the Social Security Act.

“RETIRED WORKER” “Retired Worker” means a Covered Worker who ceases to be a Worker and continues coverage under Section B of the Article of the Plan titled “CONTINUATION COVERAGE.”

“SERVICE IN THE UNIFORMED SERVICES” means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

“SKILLED NURSING FACILITY” means a facility which meets the following:

- 1. is regularly engaged in providing skilled nursing care for sick and injured persons;
- 2. requires that the patient be regularly attended by a physician;
- 3. maintains a daily record of each patient;

GENERAL TERMS AND DEFINITIONS

4. provides 24-hour nursing care which is supervised by a registered nurse;
5. is not, except incidentally, a home for the aged, a hotel or the like;
6. is not, except incidentally, a place for the treatment of Mental Health and Substance Abuse; and
7. is licensed as a Skilled Nursing Facility, if such licensing is required.

“SPONSORING ORGANIZATIONS” means the Synod, Member Congregations and Affiliated Agencies.

“SPOUSE” Except as provided in the following sentence, “Spouse” means the Spouse of an individual as determined under the laws of the individual’s state of residence. The previous sentence notwithstanding, the “Spouse” of an individual shall not include anyone who is the same gender as that individual.

“SUBSTANCE ABUSE” means the use of a psychoactive substance in a manner detrimental to society or the Member and which meets, or with continued use may meet, criteria for Substance Abuse or drug dependency.

“SURVIVING SPOUSE” means the Spouse of a deceased Covered Worker who maintained family or employee plus Spouse coverage under the Plan at the time of his or her death.

“SURVIVING SPOUSE COVERAGE” means coverage offered under Section A of the Article of the Plan titled “CONTINUATION COVERAGE.”

“SYNOD” means the Wisconsin Evangelical Lutheran Synod.

“TOTALLY DISABLED” means that the Member is entitled to Medicare benefits on the basis of disability.

“THIRD PARTY ADMINISTRATOR” means **Claim Management Services, Inc. (CMS)**.

“TRUST” means the trust that the Synod established to fund Plan benefits.

“UNIFORMED SERVICES” means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

“USUAL AND CUSTOMARY” means the fee usually and customarily accepted as payment for the same services within a geographical area in which the physician practices as determined by the Third Party Administrator.

In the case of a PPO Provider, Usual and Customary is the negotiated PPO discount rate for the service or procedure.

GENERAL TERMS AND DEFINITIONS

“VEBA COMMISSION” means the committee appointed by Synod that is responsible for the maintenance and administration of the Plan.

“WORKER” means the following employees, called individuals and Synodical students:

- A.** A person who is hired, or called, and compensated by any Sponsoring Organization, but excluding persons employed on a special, probationary, part-time or temporary basis. For purposes of the Plan:
 - 1.** Part-time basis means customarily less than 20 hours a week; and
 - 2.** Temporary basis means customarily less than 5 months a year.
- B.** Students who have attained age 19 and are enrolled in a Synodical school for the primary purpose of entering into a full-time teaching or preaching ministry.

The Administrator, in its sole discretion, shall determine who qualifies as a “Worker.” Any classification, reclassification or other characterization of any individual as a Worker of the Synod or a Sponsoring Organization, whether as a statutory, common law employee or otherwise, by a court of law or by action of any federal, state or local governmental agency shall not affect the exclusion of such individual from participation in the Plan. Any individual whom the Administrator determines is not a Worker shall not be treated as a Worker hereunder solely because he/she has been classified or reclassified as a Worker or employee of the Synod or a Sponsoring Organization by any court or government agency.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of Claim Management Services, Inc. as Third Party Administrator. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the Plan Administrator as the agent for service of legal process. The Administrator may delegate any of its powers or responsibilities among such individuals or entities as the Administrator deems appropriate. The WELS Benefit Plans Office provides services on behalf of the Administrator.

Benefit Claim Procedures and Appeal Procedures for Claims

Claims for benefits under the Plan should be directed to Claim Management Services, Inc. at the address listed below.

Appeals (other than appeals of Urgent Care claim determinations) must be made in writing to the attention of the "Appeal Department" at the address listed below.

Urgent Care claims and appeals of Urgent Care claim determinations can be made in writing to the address listed below or, during CMS's normal business hours, by fax or telephone at the numbers listed below.

Claim Management Services, Inc.
PO Box 10888
Green Bay, WI 54307-0888

Telephone Number: 1-800-472-7130 Extension 5570

Fax Number: (920) 494-4011

Proof of Claim

Written proof of a claim must be submitted to the Plan by the Member or the provider of service within 12 months after the date such claim is incurred. No claim shall be eligible for payment if it is submitted more than 12 months from the date the claim was incurred. A claim shall be considered as incurred on the date the services or supplies are rendered or received.

Procedures Upon Initial Filing of a Claim

The following procedures apply to an initial filing of a claim with the Plan:

Time Limits on Decisions: The time frame for processing the Member's initial claim depends on the type of claim it is: urgent care, concurrent care, pre-service or post-service. The Member's claim will be processed according to the highest priority category that applies to it.

- 1. Urgent Care Claims:** If a Member's claim is an urgent care claim for which the Plan requires pre-certification, the Plan will notify the Member as soon as possible, taking into

GENERAL INFORMATION

account the medical exigencies. A determination will be sent to the Member no later than 72 hours after the Plan's receipt of the Member's claim.

If the Member fails to provide sufficient information to allow the Plan to make its determination, the Plan will notify the Member as soon as possible, but not later than 24 hours after the Plan receives the Member's claim. The Member will have a reasonable period of time (not less than 48 hours) to respond and provide the additional information. After the Plan receives this additional information, the Plan will notify the Member as soon as possible whether his or her benefit claim has been granted or denied. This notification will occur no later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information; or (2) the end of the period granting the Member additional time to provide the additional information.

An urgent care claim is any claim for medical care or treatment where using the non-urgent care claim time-frames:

- a) Could seriously jeopardize the Member's life or health or ability to regain maximum function; or
 - b) Would, in the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- 2. Concurrent Care Conditions:** If the Member is currently receiving ongoing treatment or the treatment is going to be provided over a number of sessions, special rules apply:
- a) Any notice of reduction or termination (except by Plan amendment or termination) will be given to the Member by the Plan at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review before the benefit is reduced or terminated.
 - b) Any request made by the Member to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, will be decided by the Plan as soon as possible taking into account medical exigencies. Notice to the Member will be made within 24 hours after the Plan receives the request, as long as the Plan receives his or her claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- 3. Pre-Service Claim:** For a pre-service claim, the Plan will notify the Member of the decision within a reasonable period of time appropriate to the medical circumstances. This notification will be made no later than 15 days after the Plan receives the Member's claim.

The 15-day period may be extended for an additional 15 days if:

- a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and
- b) The Plan notifies the Member, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

A pre-service claim means any claim for a benefit under the Plan where the Plan conditions receipt of the benefit (in whole or in part) on approval of the benefit in advance of obtaining medical care.

- 4. Post-Service Claim:** For a post-service claim, the Plan will notify the Member of the decision within a reasonable period of time. This notification will be made not later than 30 days after receipt of the claim by the Plan.

The 30-day period may be extended for an additional 15 days if:

- a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and
- b) The Plan notifies the Member, prior to the end of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

A post-service claim is any claim under the Plan that does not satisfy the definitions of the other types of claims.

Failing to Follow the Plan's Procedures for Filing a Claim: If the Member fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the Member as soon as possible, but not later than five days after the failure (24 hours if the failure involved urgent care). This notification can be oral, unless the Member requests that it be in writing.

Manner and Content of Notification of Benefit Determination

If the Plan denies the Member's claim for benefits, the Plan will provide the Member with a written or electronic notification of this determination.

Appeal of Adverse Benefit Determination

If the Plan issued an adverse benefit determination on a claim submitted by the Member, the Member has a right to appeal the adverse benefit determination to the Plan Administrator. This review will:

1. Provide the Member with the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

GENERAL INFORMATION

2. Provide that the Member will be provided, upon request and free of charge, reasonable access to, or any copies of, all documents, records and other information relevant to his or her claim for benefits;
3. Take into account all comments, documents, records and other information submitted by the Member relevant to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. Provide that the Member has up to 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 90 days following receipt of the first appeal determination to request a final appeal;
5. Not afford deference to the initial adverse benefit determination and provide that the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
6. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, an appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
7. Identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Member's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
8. Provide that the health care professional who provides consulting services will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination nor the subordinate of any such individual;
9. Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which:
 - a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Member; and
 - b) All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Member by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

If the Member appeals an adverse benefit determination, the Plan will respond to his or her appeal within certain time limits:

- 1. Urgent Care Claims.** In the case of a claim involving urgent care for which the Plan requires pre-certification, the Plan will notify the Member of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Member's request for review of an adverse benefit determination.
- 2. Pre-Service Claims.** For pre-service claims, the Plan will notify the Member of the decision within a reasonable period of time appropriate to the medical circumstances. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 15 days after the Plan receives the Member's request for review of an adverse benefit determination.
- 3. Post-Service Claims.** For post-service claims, the Plan will notify the Member of the decision within a reasonable period of time. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 30 days after the Plan receives the Member's request for review of an adverse benefit determination.

Manner and Content of Notification of Benefit Determination on Review

The Plan will provide the Member with written or electronic notification of the Plan's benefit determination and review.

The Plan Administrator will have the sole discretion to make the determination of all final appeals. First appeals will be determined by the Third Party Administrator or its designee. Benefits under the Plan will be paid only if the Plan Administrator (or its designee) decides in its full and absolute discretion that the Member is entitled to such benefits.

If any time limitation stated in this section is less than that required by law, the limitation is extended to agree with the minimum period permitted by law.

The Plan will not be liable for any benefits after the date the Plan has terminated.

Calculation of Plan Maximum Amounts

Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Clerical Error

Clerical error on the part of the Plan Administrator or Third Party Administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by the Plan Administrator. The Member agrees to reimburse the Plan for any payment made to or for the Member in error.

Conformity With Government Law

If a provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Cost Sharing Provisions

Typically, these terms are used in the “Schedule of Benefits” section of the Plan. The Plan may use one or more of these terms.

“Deductible” generally means an amount which is reduced from eligible charges before benefits of the Plan are payable. It is the Member’s responsibility to pay the deductible amount.

“Coinsurance” generally means the percentage of the eligible charges for covered services and supplies which the Plan will pay —subject to all of the provisions of the Plan. It is the responsibility of the Member to pay for the percentage of coinsurance not payable by the Plan.

“Co-payment” generally means a fixed amount of money that a Member is required to pay toward the cost of a specified service or supply that is covered by the Plan.

“Non-compliance Penalty” generally means an amount that is reduced from eligible charges due to a failure to comply with specified provision requirements of the Plan. Any amount not covered by the Plan due to a non-compliance penalty is the responsibility of the Member.

The Member will also be responsible to pay for charges that the Plan will not cover such as those that exceed the Usual and Customary amount covered by the Plan for a service or supply, charges for amounts that relate to services or supplies that are not covered by the Plan and charges for amounts that exceed the Plan’s benefit maximums or Plan maximums.

When a Member obtains health care services through BlueCard outside the geographic area CMS serves, the amount a Member pays for covered services is calculated on the lower of:

- the billed charges for a Member’s covered services; or
- the negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes onto CMS.

Often, this “negotiated price” will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a Member’s health care Physician/Provider or with a specific group of Physicians/Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with a Member’s health care Physician/Provider or with a specified group of Physicians/Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount a Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a Member’s liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate a Member’s liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, CMS would then calculate a Member’s liability for any covered health care services in accordance with the applicable state statute in effect at the time a Member received his/her care.

GENERAL INFORMATION

Creditable Coverage

The period of any pre-existing condition limitation under a plan that would otherwise apply to a Member is reduced by the number of days of Creditable Coverage such individual had as of the enrollment date subject to the following:

1. days of Creditable Coverage that occur before a significant break in coverage will not be counted toward satisfying any pre-existing condition limitation provision of the Plan;
2. the amount of Creditable Coverage is determined by counting all of the days the individual had Creditable Coverage from one or more sources, provided that any days in a waiting period for a plan or policy are not considered Creditable Coverage; and
3. any coverage that is "Excluded Coverage" shall not be included as Creditable Coverage.

Procedure for Certificates of Coverage

An individual who wishes to receive a Certificate of Coverage for periods under this Plan should contact the Plan Administrator whose address is given in the "Plan Information" section of the Plan.

Appeal Process for Determination of Creditable Coverage

A Member who wishes to appeal an adverse determination of his or her Creditable Coverage by the Plan may appeal the determination by following the procedures in the provision entitled "Benefit Claim Procedures and Appeal Procedures for Claims" in the General Information section of the Plan. In such instances, an appeal of an adverse determination of Creditable Coverage will be handled in the same manner as if the adverse determination had been a denial of a claim for benefits under the Plan.

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service, HMO or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Master Plan Document

The Master Plan Document, including all its schedules, provisions, exclusions, limitations, and appendices, as amended from time to time, constitutes the entire Plan.

Medical Care Provided By The United States

The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related illness or injury. The Plan will also reimburse eligible

GENERAL INFORMATION

charges for medical care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between “new” drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Newborns’ and Mothers’ Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Under the Plan, maternity stays exceeding either the 48 hour or 96 hour period, require certification by the CMS Managed Care Department or benefits may not be payable for the remainder of the Hospital stay.

Participant Contribution

A participant contribution is the amount a Worker is required to pay in order to participate in the Plan. Contact your Employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "COBRA Continuation Coverage" will receive a separate notice which will indicate the cost to participate in the Plan.

Payments Directly To Providers

The Plan shall pay a non-BlueCard provider directly for health care services rendered by such provider to a Member, unless otherwise specified by the Covered Worker. For claims from BlueCard providers, the Plan shall pay a provider directly for health care services rendered by such provider to a Member pursuant to Blue Cross and Blue Shield Association rules.

Payments Made Prior To Determining Final Liability

The Member shall reimburse the Plan for any payment made by the Plan which is subsequently determined by the Plan to be in excess of the amount required to be paid by the terms of the Plan.

Physical Examination

The Plan at its expense shall have the right and opportunity to have the Member examined for evaluation and verification of an Illness or Injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination

Although the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. In addition to the Plan Sponsor, the Plan Administrator may amend or modify the Plan, in whole or in part, at any time. Such amendment of the Plan shall be in writing and executed by an officer or other individual authorized by the Plan Administrator. No amendment shall cause or permit any portion of Trust assets to be diverted to purposes other than for the exclusive benefit of Members, or cause or permit any portion of Trust assets to revert to or become the property of any Sponsoring Organization.

By written resolution, the Synodical Council may terminate this Plan or authorize the Plan Administrator to terminate this Plan. If the Synodical Council terminates the Plan, the termination will become effective when the Plan Administrator receives written notice of the termination executed by the President and the Secretary of the Synod or on the date specified in the written notice. The termination notice must contain the statement that any assets remaining in the Trust shall be used for life, sickness, accident or other benefits within the meaning of section 501(c)(9) of the Code.

Plan Administration and Interpretation

The Plan Administrator shall administer the Plan in accordance with its terms and shall discharge its duties with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. The Plan Administrator shall have all powers necessary to manage and control Plan operations and administration. The Plan Administrator shall have full and complete authority and control with respect to Plan operations and administration unless the Plan Administrator allocates and delegates such authority or control pursuant to the procedures stated in subsection (b) or (c) below. Any decision of the Plan Administrator shall be made in its sole and absolute discretion and shall be final and binding on all Members, all Employers, Sponsoring Organizations, and all other persons or parties. The powers of the Plan Administrator include, but are not limited to, the following:

- a) To employ such accountants, counsel or other persons as it deems necessary or desirable in connection with Plan administration, and to pay the costs of such services and other administrative expenses from the Trust, unless paid by the Synod or an Employer;
- b) To designate in writing persons other than the Plan Administrator to perform any of its powers and duties hereunder including, but not limited to, Plan fiduciary responsibilities (other than any responsibility to manage or control the Plan assets);
- c) To allocate in writing any of its powers and duties hereunder, including but not limited to fiduciary responsibilities (other than any responsibility to manage or control the plan assets) to those persons who have been designated to perform Plan fiduciary responsibilities;
- d) To construe and interpret the Plan;

GENERAL INFORMATION

- e) To resolve all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, questions as to the eligibility or the right of any person to participate in or to receive any benefit from the Plan;
- f) To adopt such by-laws, rules, regulations, forms and procedures from time to time as it deems advisable and appropriate in the proper administration of the Plan;
- g) To receive from an Employer or from Members such information as shall be necessary for the proper administration of the Plan;
- h) To receive from the trustee for the Plan, and review, reports of the financial condition and receipts and disbursements of the Trust;
- i) To collect and receive all contributions payable to the Trust in accordance with the Plan, and to authorize benefit payments and charges from the Trust as provided by the Plan;
- j) To insure benefits with an insurance company or companies and negotiate and enter into insurance contracts;
- k) To prescribe procedures to be followed by any person in applying for Plan benefits and to designate the forms or documents, evidence and such other information as the Plan Administrator may reasonably deem necessary, desirable or convenient to support an application for such distribution; and
- l) To apply consistently and uniformly its rules, regulations and determinations to all Members in similar circumstances.

Pursuant to subsections (b) and (c) above, the Plan Administrator has contracted with Claim Management Services, Inc. to process claims, maintain Plan data, and perform other Plan connected services.

The Plan Administrator may exclude from the Plan, other provisions notwithstanding, a Sponsoring Organization or Workers of any Sponsoring Organization who are foreign nationals or residents in a foreign country, if the inclusion of such Workers would affect the status of the Trust as an exempt trust under section 501 of the Code, or if the Plan Administrator determines that the Plan would not operate in the best interest of such Workers, or if the inclusion of such Workers would present excessively complicated or difficult problems in the administration and operation of the Plan.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between any Sponsoring Organization and any Worker or other person or to be a consideration for, or an inducement or condition of, the employment of any Worker. Nothing in the Plan shall be deemed to give any Worker the right to be retained in the service of an Employer, or to interfere with or abridge the right of, an Employer to discharge any Worker at anytime.

Plan Maximums and Benefit Maximums

Plan Maximums” generally means the total amount the Plan will pay for any Member while he or she is a Member in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

“Benefit Maximums” generally means the Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an Illness or Injury. These limitations may also be expressed in other terms, for example, a number of days, visits or Confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Plan’s Rights to Subrogation and Reimbursement

If a Member incurs medical, dental, prescription drug or disability expenses for an Illness or Injury because of the fault, in whole or in part, of another person, that other person may be legally responsible for those medical, dental, prescription drug or disability expenses. Furthermore, a Member or the Member's guardian or estate may be entitled to receive money from an insurance contract for medical, dental, prescription drug or disability expenses resulting from an Injury or Illness. The Plan will be subrogated to all rights of recovery the Member or the Member’s guardian or estate may have against such other person or persons and such insurance contract or contracts for medical, dental, prescription drugs or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the Member or the Member's guardian or estate.

The Plan shall have the right to receive payment or repayment of those expenses referred to above from the person or persons that caused the Illness or Injury, any person who has legal responsibility for that person, that person's liability insurer, or any other insurer providing coverage for that person. The Plan shall also have the right to recover expenses it has paid or is obligated to pay from amounts paid for those expenses referred to above from the Member’s or his or her guardian's or estate’s auto insurance including but not limited to uninsured or underinsured motorist coverage and med pay.

The Plan shall have “dollar one” recovery entitlement from any amounts **paid** and not simply from amounts received, regardless of whether the Member or the Member’s guardian or estate is "made whole". The Plan’s recovery shall not be reduced because of any alleged or actual comparative or contributory negligence on the part of the Member.

The Plan is automatically assigned the Member's or the Member’s guardian's or estate’s right of recovery against third parties (including their insurers) who are responsible in whole or in part for causing the Injury or Illness, to the extent of amounts the Plan has paid or is legally obligated to pay in the future for the medical, dental, prescription drug or disability expenses of the Member. The Plan will be entitled, but not obligated, to proceed in the name of the Member or the Member’s guardian or estate against the person or persons responsible to repay the Plan for expenses the Plan has incurred for the Member as identified above, if the Member or the Member’s guardian or estate fails to take the necessary action to recover such expenses.

GENERAL INFORMATION

If the Plan pays any claims which are subsequently determined to be payable or reimbursable by a third party, then the Member or the Member's guardian or estate agrees to reimburse the Plan for claims paid by the Plan out of any settlement, recovery, judgment, award, or payment made to or on behalf of the Member or the Member's guardian or estate.

The amount of the Plan's subrogation claim must be included in any litigation filed or any claim made or asserted by or for the Member or the Member's guardian or estate in connection with the Injury or Illness giving rise to the expenses referred to above including claims made against the Member's own insurer. When the claim is settled or any amount is paid to the Member or the Member's guardian or estate or his or her legal representative, then the person receiving such funds must reimburse the Plan or cause the Plan to be reimbursed for medical, dental, prescription drug or disability expenses that the Plan has paid or that it is legally obligated to pay in the future to or on behalf of the Member..

The Member or the Member's guardian or estate shall not prejudice the Plan's rights of subrogation and reimbursement and shall sign and deliver documents to evidence or to secure those rights to the Plan. The Plan has the right to receive from the Member or the Member's guardian or estate, prior to the Plan's payment of claims or at any time subsequent thereto, a completed subrogation questionnaire, a reimbursement agreement and an acknowledgment of the Plan's subrogation reimbursement and recovery rights signed by the Member or the Member's guardian or estate, or his or her authorized legal representative, on forms provided by the Plan.

The Member, or the Member's guardian, or estate is not authorized to obtain legal representation, to act on behalf of the Plan for recovery of any amounts paid by the Plan. Any contingent fee or retainer agreement entered into by the Member or the Member's guardian or estate will have no effect on the Plan's entitlement to the full amount of its subrogation claim on a "dollar one, first priority basis", regardless of any asserted offset for attorney fees or costs or other reduction unless specifically agreed to in writing by the Plan. This also applies to any other similar federal or state common law which would cause the Plan to receive less than the full amount of its claim. The concepts of the "fund doctrine," the "common fund doctrine," or the "Attorney's Fund Doctrine" that govern the allocation of attorney's fees do not apply to this Plan or its rights to subrogation and recovery. The Plan may, at its discretion, enter into an agreement with the Member or the Member's guardian or estate, or his or her legal representative to represent its subrogation interest.

The Plan's rights as provided in this "Plan's Rights to Subrogation and Reimbursement" provision of the Plan document are created and preserved regardless of whether the Member or the Member's guardian or estate is "made whole," signs a reimbursement agreement, or signs an acknowledgment of the Plan's subrogation and recovery rights. The Member or the Member's guardian or estate, or his or her legal representative shall make no distributions nor authorize any distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien or the expenses for medical, dental, prescription drug, or disability expenses that the Plan has paid or that it is legally obligated to pay in the future to or on behalf of the Member without the written approval of the Plan and shall not release any party or their insurer without the prior written approval of the Plan. In addition, the Member or the Member's guardian or estate, or his or her legal representative will not withhold or intercept any

GENERAL INFORMATION

amounts due the Plan from any party. Additionally, the Member or the Member's guardian or estate, or his or her legal representative shall not instruct any party to forward amounts owed to the Plan, to any entity other than the Plan, in the absence of a prior written agreement with the Plan or its Third Party Administrator.

The subrogation rights of the Plan shall be superior to and the Plan shall have "first priority" over any competing claims of the Member or the Member's guardian or estate, or his or her legal representative, or any competing claims of a parent, Spouse, or child of a Member, to any designated or undesignated proceeds of a judgment, award, or insurance settlement of the claims of the Member, or of any other person where such settlement, judgment or award relates to or arises from the circumstances giving rise to the medical, dental, prescription drug or disability expenses of the Member that the Plan has paid or that the Plan is legally obligated to pay in the future to or on behalf of the Member. The Plan may require the Member or the Member's guardian or estate, or his or her legal representative to reimburse the Plan for any attorney's fees, court costs or other expenses incurred by the Plan in enforcing its rights to subrogation and reimbursement.

A Member also includes any Dependent of the Member where applicable.

Presumption of Receipt of Information

It shall be presumed that any information, notification or decision, provided by the Plan through the U.S. Mail, to a Member or provider located in the United States is received by the Member or provider within three (3) days of the date of mailing.

Preventive Services

The Plan provides information on coverage provided or excluded by the Plan for preventive health benefits or wellness benefits. This information is located in the Schedule of Benefits, Comprehensive Medical Benefits or Limitations and Exclusions of the Medical Plan sections of the Plan. As is the case with all benefits of the Plan, these services are subject to all the provisions of the Plan including, the limitation that such services not be "Experimental or Investigational".

Privacy and Security of Protected Health Information

1. Plan Sponsor's Certification of Compliance.

Neither the Plan nor any business associate servicing the Plan will disclose the Plan Participants' Protected Health Information, including any Electronic Protected Health Information, as defined by 45 Code of Federal Regulations (CFR) §160.103, to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Plan Sponsor.

- a) The Plan and any business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its

implementing regulations (45 CFR Parts 160-64). Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.

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

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

- a) The Plan Sponsor will neither use nor further disclose the Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.
- b) The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides the Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to the Plan Participants' Protected Health Information, including implementation of reasonable and appropriate security measures to protect such Protected Health Information in accordance with 45 CFR §164.314(b)(2)(iii).
- c) The Plan Sponsor will not use or disclose the Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor.
- d) The Plan Sponsor will report to the Plan any use or disclosure of the Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure. Additionally, pursuant to 45 CFR §164.314(b)(2)(iv), the Plan Sponsor will report to the Plan any security incident of which it becomes aware, under the following conditions. If a security incident results in an actual disclosure of Protected Health Information not permitted herein, the Plan Sponsor will report such incident to the Plan. The Plan Sponsor will report to the Plan any unauthorized: (1) access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware; or (2) interference with system operations in the Plan Sponsor's information systems, involving the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware.
- e) The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 CFR §164.524.
- f) The Plan Sponsor will make the Plan Participants' Protected Health Information available for amendment, and will on notice amend the Plan Participants' Protected Health Information, in accordance with 45 CFR §164.526.

- g) The Plan Sponsor will track disclosures it may make of the Plan Participants' Protected Health Information that are accountable under 45 CFR §164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- h) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of the Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 CFR Part 164, Subpart E "Privacy of Individually Identifiable Health Information."
 - i) The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all of the Plan Participants' Protected Health Information, in whatever form or medium, received from the Plan or any business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all of the Plan Participants' Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any of the Plan Participants' Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

4. Adequate Separation Between the Plan Sponsor and the Plan.

The following employees or classes of employees or other workforce Members under the control of the Plan Sponsor may be given access to the Plan Participants' Protected Health Information received from the Plan or a business associate servicing the Plan:

Members of the WELS VEBA
Commission

Workers of the WELS VEBA Benefit
Plan Office

This list includes every employee or class of employees or other workforce Members under the control of the Plan Sponsor who may receive a Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

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

GENERAL INFORMATION

of the employees, or classes of employees identified above, is supported by reasonable and appropriate security measures, in accordance with 45 CFR §164.314(b)(2)(ii).

5. Safeguard Requirement.

Pursuant to 45 CFR §164.314(b)(2)(i), the Plan Sponsor will implement administrative, physical, and technical safeguards to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

Rescission of Coverage

The Plan has the right to rescind coverage for which any Worker or Member made a material misrepresentation on his or her application for coverage form or change notice form. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the Worker or a Member or cover a medical condition of the Worker or a Member when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the Worker, Member or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Right of Recovery For Payments Made

The Plan reserves the right to recover payments made under the Plan in the amount by which the payments exceed the maximum amount required to be paid under the provisions of the Coordination of Benefits section, through the BlueCard Program, or any other provisions of the Plan. In the discretion of the Plan Administrator, such recovery may include the reduction in the payment by the Plan of the future benefits properly payable under the Plan. This right of recovery applies against:

1. any person to whom, for whom, or with respect to whom such payments were made;
or
2. any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other Plan.

Rights With Respect To Medicaid

Payment of benefits with respect to a Member under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Member as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a Member in the Plan or in determining or making any payments for benefits of an individual as a Member, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

GENERAL INFORMATION

To the extent that payment has been made under a State Plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a Member in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a Member for payment for such supplies, services or treatments.

Self-funding

All contributions to the Plan shall be committed in trust to the Plan Administrator and contributed to a Trust under the Plan. Except as expressly provided in the Plan, no Member, Retired Member or any other person shall have any right to Trust assets. Plan benefits are limited to the assets of the Trust.

The Plan Administrator has entered into a legal arrangement with the Third Party Administrator to help ensure accurate, impartial and timely payment of benefits to, and on behalf of, Members and their covered Dependents.

Summary Plan Descriptions

The Plan Administrator will issue to each Covered Worker, COBRA participant, Surviving Spouse covered under the Plan, and Retired Worker covered under the Plan, a summary plan description which summarizes the benefits to which the Member is entitled. This booklet is intended to satisfy the requirements of a summary plan description, as specified in ERISA.

Use of Network or PPO Providers

Preferred Provider Organizations are referred to in the Plan as PPOs and medical providers within those PPOs are referred to as network providers or PPO providers. The section of the Plan entitled "Information Regarding PPO and Non-PPO Providers" provides general information regarding the use of PPO providers. In addition, the Schedule of Benefits section of the Plan indicates how benefits of the Plan will be determined, depending on whether and how the participant uses a PPO provider. Generally, a Member will receive a greater benefit under the Plan if he or she elects to use the services of a PPO provider and may receive a lesser benefit if he or she elects to use a Non-PPO provider. If the distinction between PPO and Non-PPO providers is applicable to the Plan, then the Schedule of Benefits provides information which describes the instances for which a Member may receive the PPO level of benefits, even though a Non-PPO provider is used.

The Plan Sponsor reserves the right to change networks and PPOs at any time.

A separate description of the network and a listing of PPO network providers can be obtained automatically, without charge, from the Plan Administrator or Third Party Administrator.

Usual and Customary Procedure

CMS will cover the amount which is usually and customarily charged for that type of service. The amount in excess of the Usual and Customary fee may be pended for additional information. The Covered Worker will be notified on the Explanation of Benefits or by letter that CMS is requesting additional information. CMS will then contact the provider, which will give the provider the opportunity to supply CMS with additional information which may explain the

GENERAL INFORMATION

higher fee. This may include an operative report or medical records if signed authorization is received from the Covered Worker. If after receiving the additional information, the higher amount cannot be justified, CMS will outline the reasons for the denial.

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any Injury or Illness occurring during, or arising from, the Worker's course of employment.

PLAN INFORMATION

PLAN SPONSOR:

Wisconsin Evangelical Lutheran Synod
2929 North Mayfair Road
Milwaukee, WI 53222-4304
(414) 256-3860

ADMINISTRATOR, PLAN ADMINISTRATOR AND NAMED FIDUCIARY:

WELS VEBA Commission
c/o Wisconsin Evangelical Lutheran Synod
Benefit Plans Office
2949 North Mayfair Rd., Suite 116
Milwaukee, Wisconsin 53222-4392
(414) 256-3860

ADMINISTRATOR IDENTIFICATION NUMBER:

39-1522925

NAME OF PLAN:

WELS VEBA Group Health Care Plan
This document describes the High Deductible Plan Option under the WELS VEBA
Group Health Care Plan

EMPLOYER IDENTIFICATION NUMBER:

39-1522925

PLAN NUMBER:

501

FUNDING AND SOURCES OF CONTRIBUTIONS:

Synod, Sponsoring Organization and Member contributions are held in a trust established under section 501(c)(9) of the Code.

TRUSTEE:

Marshall and Ilsley Trust Company
1000 North Water Street
Milwaukee, WI 53202

TYPE OF PLAN:

The Plan is a welfare plan designed to provide group medical and prescription drug benefits.

TYPE OF ADMINISTRATION:

GENERAL INFORMATION

The Plan is administered on a contract administration basis. The Third Party Administrator provides administrative services to the Plan.

THIRD PARTY ADMINISTRATOR:

Claim Management Services, Inc.
P.O. Box 10888
Green Bay, WI 54307-0888
1-800-472-7130

AGENT FOR SERVICE OF LEGAL PROCESS:

WELS VEBA Commission
c/o WELS Benefit Plans Office
2949 North Mayfair Road, Suite 116
Milwaukee, WI 53222
(414) 256-3860

FINANCIAL RECORDS:

The financial records of the Plan are kept on a Plan Year basis ending on each December 31st.

STATEMENT OF ERISA RIGHTS

As a person covered under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Members shall be entitled to:

1. examine, without charge at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies; and
3. receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You may continue health care coverage for yourself, Spouse or 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. Review this Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided with a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 certain steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

STATEMENT OF ERISA RIGHTS

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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If it should happen that the 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 a 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 court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.