

DENTAL AND EXCESS MEDICAL CERTIFICATE

Please read this certificate, including all endorsements, if any, carefully, so you know and understand your coverage.

Use Your EPIC Identification Card. Please be sure to show your EPIC identification card each time you or any of your covered dependents go to your physician, hospital or other health care provider.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group medical insurance policy (hereinafter called "group policy" or "policy") issued by EPIC to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

You are responsible for choosing your health care provider. The physicians, hospitals and other health care providers are independent contractors and are not employed by EPIC. EPIC merely provides benefits for covered expenses in accordance with the group policy. EPIC does not provide health care services. EPIC does not warrant or guarantee in any way the quality of the health care services directly provided by any health care provider. EPIC is not liable or responsible in any way for the provision of such health care services by any health care provider. Please see Section XI. A. of this certificate.

The insurance described in this certificate limits charges for covered expenses to the amounts we determine as being reasonable. This amount may be less than the amount billed. Please see the definition of "charge" in Section II. Definitions. If you would like more information, please contact our EPIC Customer Service Department by calling the telephone number shown on your EPIC Identification Card.

EPIC, in performing its obligations under the policy, is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state law.

The group policy is issued by EPIC and delivered to the policyholder in the State of Wisconsin. All terms, conditions and all other provisions of the group policy are governed by the laws of the State of Wisconsin. All benefits are provided in accordance with the terms, conditions, exclusions, limitations and provisions of the group policy, including all endorsements, if any, attached to this certificate, and applicable Wisconsin laws.

THE EPIC LIFE INSURANCE COMPANY

James R. Riordan, President

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SECTION I. GENERAL INFORMATION

A. General Description of Coverage

EPIC certifies that a group policy has been issued to a group insuring certain employees of the group. We call the group the policyholder. Those persons to whom we've issued certificates are called covered employees. Covered employees are also called members. If a covered employee is issued limited family or family coverage under the group policy, his/her eligible dependents whom we approved for coverage are called members. The group policy forms a contract between us and the policyholder. We'll provide the insurance described here under the terms, conditions and provisions of that contract. Subject to that contract, each member is insured for the coverage described in this certificate. Please see Section XI. J. Entire Contract.

B. Coverage

Coverage is subject to terms, conditions, exclusions, limitations, and all other provisions of the policy. As a certificate, this document describes the essential features of the insurance provided by the policy

This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to the covered employee prior to the effective date of this certificate.

C. How to Use This Certificate

This certificate, including all endorsements, should be read carefully and completely by you. You should also review this certificate periodically. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in Section II. Definitions. By understanding these definitions, you will have a clearer and better understanding of your coverage under the policy as described in this certificate by us. That means your coverage under the policy will change to the extent described in the endorsement, as of the effective date of that endorsement.

From time to time, the policy may be amended by us. When that happens, a new endorsement for this certificate will be sent by us to the policyholder for its delivery to each covered employee. This certificate should be kept in a safe place for your future reference.

D. Covered Expenses

Benefits are payable only for charges for covered expenses under the policy. The fact that a physician has performed or prescribed a treatment, service or supply or the fact that it may be the only available treatment, service or supply for an illness or injury does not mean that the treatment, service or supply is covered under the policy. EPIC has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions, and all other provisions of the policy, including, but not limited to, making factual determinations under the policy's provisions, including, but not limited to, whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy. Other than EPIC, no person or entity has any authority to make any oral changes or amendments to the policy. Please also see Section XI. K. Waiver and Change.

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the policy, including claims processing and utilization review management services. Their identity and the nature of the services being provided by them may be changed by us at any time at our sole discretion, and without giving prior notice to you, or getting your approval. By accepting this certificate, you agree to and must cooperate fully with those persons or entities in the performance of their responsibilities.

SECTION II. DEFINITIONS

In this certificate, the following words shall mean:

Active Work/Actively at Work: when an employee is performing all of the full-time duties of his/her principal occupation in his/her job with the policyholder for the required number of hours per week as shown in the policyholder's current WPS application for coverage, and paid a reasonable wage, as determined by us. These duties must be performed at the policyholder's place of business, except to the extent that the employee must travel to perform his/her duties. The employee shall be deemed to be actively at work on: (a) each day of a paid vacation; or (b) a regularly-scheduled non-work day, provided that, in either case, he/she worked his/her entire last regularly-scheduled work day prior to such date.

Alcoholism: a health condition listed in the latest edition of American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Disease (ICD-9-CM) within a classification category or code 303, 304 and 305 and 291 or 292.

Annuitant: a person retired by the policyholder who is eligible for the group insurance plans issued pursuant to Chapter 40, relating to group health insurance for state employees, and the surviving spouse of an annuitant as defined in Chapter 40. An insured who becomes an immediate annuitant upon retirement or a surviving spouse of an insured shall be allowed to continue under the group plan at group plan rates including any portion paid by the policyholder, providing application is made within 30 days from the date the insured becomes an annuitant.

Basic Plan: (a) the Standard Plan or any other plan or plans providing benefits or services arranged through the policyholder and any benefits paid or payable by the plans in the absence of any other coverage; (b) Medicare and State Medicare Plus \$100,000; or (c) or any other plan offered by a policyholder.

Calendar year: the period that starts with the effective date shown in our records and ends on December 31st of such year. Each following calendar year shall start on January 1st of any year and end on December 31st of that year.

Certificate: the document issued by us to a covered employee who is insured under the policy issued by us to the policyholder. It is not a contract of insurance, but only evidence of coverage, and describes the essential features of the insurance provided by the policy.

Charge: an amount for a health care service directly provided to you by a health care provider that is reasonable, as determined by us, when taking into consideration, among other factors (including national sources) determined by us, amounts charged by health care providers for similar health care services when provided in the same geographical area. The term "area" means a county or other geographical area which we determine is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount we determine as reasonable may be less than the amount billed. If any health care provider has a contract with us, that provider is paid at the negotiated rate determined by us in accordance with the applicable contract between us and that provider. Charges are incurred on the date you receive the health care service.

As required by Section Ins.. 3.60, Wis. Admin. Code, as amended, upon written or oral request from you for our charge for a health care service and if you provide us with the appropriate billing code that identifies the health care service (for example, C.P.T. codes, ICD 9 codes or hospital revenue codes) and the health care provider's estimated fee for that health care service, we will provide you with any of the following:

- a. a description of our specific methodology, including, but not limited to, the following:
 - (1) the source of the data used, such as our claims experience, an expert panel of health care providers, or other sources;
 - (2) the frequency of updating such data;
 - (3) the geographic area used;
 - (4) if applicable, the percentile used by us in determining the charge; and

(5) any supplemental information used by us in determining the charge.

b. The amount allowable by us under our guidelines for determination of the reasonable portion of the amount billed by the health care provider for a specific health care service provided to you in the geographic area where you received the health care service. That may be in the form of a range of payments or maximum payment.

Benefits for charges for covered bilateral and multiple surgical procedures and for a covered surgical procedure that requires a surgical assistant or co-surgeon to be present are determined by us only as described in Section IV. B. 4. a. (1).

In some cases we may determine that the health care provider or its agent didn't use the appropriate billing code to identify the health care service provided to you. We reserve the right to recodify and assign a different billing code to any health care service that we've determined was not billed using the appropriate billing code.

Complication of Pregnancy: a health condition needing medical treatment before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: medically necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia. Complication of pregnancy does not include: false labor; occasional spotting; rest prescribed during period of pregnancy; elective cesarean section.

Confinement/Confined: the period starting with your admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with your discharge from the same hospital or other facility. If you are transferred to another hospital or other facility for continued treatment of the same or related illness or injury, it's still just one confinement.

Covered Employee: an employee eligible for coverage under the policy, who has properly enrolled, and is approved by us for coverage under the policy.

Custodial Care: health care services given to you if: (a) you do not require the technical skills of a registered nurse at all times; (b) you need assistance for activities of daily living, including, but not limited to, dressing, bathing, eating, walking, taking medications or maintaining continence; and (c) the health care services you require are not likely to improve your physical and/or mental condition. Health care services may still be considered custodial care, as determined by us, even if: (a) you are under the care of a physician; (b) the physician prescribes health care services to support and maintain your physical and/or mental condition; or (c) health care services are being directly provided to you by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

Department: The State of Wisconsin Department of Health and Social Services.

Dependent: a person who is: (a) your spouse; (b) your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward under age 19; (c) your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward under age 25, if he/she is a full-time student as determined by us; and (d) an unmarried natural child of a dependent child (as described in (b) above) until the dependent child is 18 years of age. In the case of a child placed for adoption with you, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. A person is not an eligible dependent if he/she is: (a) covered under the policy as an insured; (b) on active duty with the military service, including national guard or reserves, other than for duty less than 30 days; or (c) in the case of a child: (1) if such child provides 50% or more of his/her own support, as determined by us; or (2) such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage in accordance with Section 632.896, Wisconsin Statutes, as amended. No person shall be considered as an eligible dependent of more than one employee covered under the policy as an insured.

A dependent child who is over the limiting age stated above may remain insured as a dependent under the policy if he/she meets certain requirements, provided your family coverage remains in force under the policy. The child must: (a) be unable to support himself/herself with a job because of mental retardation or physical handicap; (b) have become disabled before he/she reaches the limiting age stated above; and (c) be principally supported by you. Written proof of the child's disabling condition must be given to us within 31 days of the child attaining the limiting age stated above. Failure to provide such proof to us within that 31-day period shall result in the termination of that dependent child's coverage in accordance with Section IX. When Coverage Ends.

Direction: verbal or written instructions, standing orders or protocols issued by a physician or health care provider.

Drug Abuse: a health condition listed in the latest edition of American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Disease (ICD-9-CM) within a classification category or code 303, 304 and 305 and 291 or 292.

Durable Medical Equipment: an item which can withstand repeated use and is, as determined by us: (a) primarily used to serve a medical purpose with respect to an illness or injury; (b) generally not useful to a person in the absence of an illness or injury; (c) appropriate for use in your home; (d) prescribed by a physician; and (e) medically necessary. All requirements of this definition must be satisfied before an item can be considered to be durable medical equipment.

Emergency Medical Care: a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- a. serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- b. serious impairment to the person's bodily functions; or
- c. serious dysfunction of one or more of the person's body organ or parts.

Employee: an employee who participates in the Wisconsin Retirement System (WRS) and is eligible for the State sponsored health insurance plans.

EPIC: The EPIC Life Insurance Company.

Expedited Grievance: means a grievance where any of the following applies:

- a. The duration of the standard resolution process will result in serious jeopardy to the life or health of the member or the ability of the member to regain maximum function.
- b. In the opinion of a physician with knowledge of the member's medical condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- c. A physician with knowledge of the member's medical condition determines that the grievance shall be treated as an expedited grievance.

Experimental or Investigative: As determined by the Corporate Medical Director, the use of any health care service for your illness or injury that, at the time it is used, meets one or more of the following:

- a. requires approval that has not been granted by the appropriate federal or other government agency, such as, but not limited to, the federal Food and Drug Administration (FDA); or
- b. isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or
- c. is the subject of either: (1) a written investigational or research protocol; or (2) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (3) an ongoing phase I, II or III clinical trial; or (4) an ongoing review by an Institutional Review Board (IRB); or
- d. doesn't have either: (1) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (2) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources we determine to be authoritative.

Additional criteria that we use for determining whether a health care service is considered to be experimental or investigative and, therefore, not covered, for a particular illness or injury include, but are not limited to:

- a. what are its failure rate and side effects;
- b. whether other more conventional methods of treatment have been first exhausted;
- c. whether it is medically necessary for the treatment of that illness or injury;
- d. whether it is universally recognized as not experimental or investigative by Medicare, Medicaid and other third party payers (including insurers and self-funded plans); or
- e. whether any documentation refers to the health care service as posing an uncertain outcome or having an unusual risk.

Investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, and drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis, are covered under the policy to the extent described in the policy, if applicable.

The determination of whether a health care service is experimental or investigative under the definition set out above and our criteria shall be made by us in our sole and absolute discretion. In any dispute arising as a result of our determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of our liability under the policy or on any other basis shall be to provide policy benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

Family Coverage: means coverage applies to you, your eligible spouse and your eligible dependent children. To be covered, a dependent must be properly enrolled and approved by us for coverage under the policy. We must also receive timely the appropriate premium to pay for his/her coverage. When referred to in this certificate, family coverage also includes limited family coverage.

Grievance: means any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a member.

Group Master Policy/Policy: the group insurance policy issued by us to the employer, trustee, union, association, organization or other entity known as the policyholder. In it, we agree to insure members of the policyholder for future treatment, services and supplies covered by the policy through benefit payments, subject to the terms, conditions and provisions of the policy.

Health Care Provider: any person, institution or other entity licensed by the state in which he/she or it is located to provide treatment, services or supplies covered by the policy to a member, within the lawful scope of his/her or its license.

Health Care Services: treatment, services, procedures, drugs or medicines, devices, or supplies directly provided to you and covered under the policy, except to the extent that such treatment, services, procedures, drugs or medicines, devices, or supplies are limited or excluded under the policy.

Home Care: care and treatment provided to you in your home under a written home care plan. The attending physician must set up the home care plan. Such plan must be approved in writing by that physician. He/she must review it at least every two months; but this can be less frequent if he/she decides longer intervals are enough and we agree.

Hospital: an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by us and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A hospital does not include, as determined by us: (a) a convalescent or extended care facility unit within or affiliated with the hospital; (b) a clinic; (c) a nursing, rest or convalescent home or extended care facility; (d) an institution operated mainly for care of the aged or for treatment of mental disease, drug addiction or alcoholism; (e) sub-acute care center; or (f) a health resort, spa or sanitarium.

Illness: a physical illness, alcoholism, drug abuse, or a nervous or mental disorder.

Immediate Family: your spouse, natural and adopted children, parents, grandparents, brothers, and sisters, and the spouses of such persons.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to your teeth is not considered an injury.

Licensed Skilled Nursing Facility: a nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These services must be provided under professional direction and medical supervision as needed.

Limited Family Coverage: means coverage applies to you and your eligible spouse or coverage applies to you and your eligible dependent child. To be covered, a dependent must be properly enrolled and approved by us for coverage under the policy. We must also receive the appropriate premium for him/her.

Low-Dose Mammography: the x-ray examination of a breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maintenance/Supportive Care: maintenance care is health care services provided to a patient after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms. Supportive care is health care services provided to a patient whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continued care.

Maternity Services: professional services for delivery and postnatal care. This includes: laboratory procedures; delivery of the newborn; cesarean and porro-cesarean sections; and care for miscarriages.

Medicaid/Medical Assistance: benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

Medically Necessary: a health care service directly provided to you by a hospital, physician or other health care provider that is required to identify or treat your illness or injury and which is, as determined by us: (a) consistent with the symptom(s) or diagnosis and treatment of your illness or injury; (b) furnished for an appropriate duration and frequency in accordance with acceptable medical practice to treat that illness or injury; (c) not solely for your convenience or the convenience of the physician, physician, hospital or other health care provider; (d) the most appropriate health care service or location for providing such health care service, which can be safely provided to you and accomplishes the desired end result in the most economical manner; and (e) supported by information contained in your medical records from other relevant sources.

Medical Services: professional services recognized by a physician in the treatment of illness or injury and directly provided to you. Not included are: maternity services; surgery; anesthesiology; pathology; and radiology.

Medical Supplies: items which are, as determined by us: (a) used primarily to treat an illness or injury; (b) generally not useful to a person in the absence of an illness or injury; (c) the most appropriate item which can be safely provided to you and accomplish the desired end result in the most economical manner; and (d) prescribed by a physician. The item's primary function must not be for the patient's comfort or convenience.

Medicare: benefits available under Title XVIII of the Social Security Act of 1965, as amended.

Member: a covered employee or one of his/her dependents who has been enrolled and approved by us for coverage under the policy.

Miscellaneous Hospital Expense: the charges for regular hospital expenses (but not room and board, nursing services and ambulance services) we cover under the policy for treatment of an illness or injury requiring either inpatient hospitalization or outpatient health care services at a hospital. For outpatient health care services, this includes charges for use of the hospital's emergency room and for emergency medical care provided to you at the hospital. Miscellaneous hospital expenses include take-home drugs.

Morbid Obesity/Morbidly Obese: when a member's Body Mass Index (BMI) is 40 or above. Body Mass Index is defined as the member's weight in kilograms divided by the square of their height in meters. A physician must define morbid obesity utilizing the method stated in this definition.

Nervous or Mental Disorders: a health condition listed in the latest edition of American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Disease (ICD-9-CM) within a classification category or code 295, 296, 297, 298, 300, 301, 302, 306, 307, 308, 309, 311, 312, 313 and 314.

Nurse Practitioner: an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws of another state and who satisfies any of the following: (a) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; (b) holds a master's degree in nursing from an accredited school of nursing; (c) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or (d) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (c) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Outpatient Treatment Facility: a facility licensed or approved by the Department. Its outpatient services must meet the Department's standards. It must provide the following outpatient services to prevent and treat an illness: (a) comprehensive diagnostic and evaluation services; (b) outpatient care and treatment, precare, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and (c) professional consultation.

Physical Illness: a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

Physician: a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides health care services while he/she is acting within the lawful scope of his/her license. A physician is limited to the following:

- a. Doctor of Medicine (M.D.);
- b. Doctor of Osteopathy (D.O.);
- c. Doctor of Dental Surgery (D.D.S.);
- d. Doctor of Dental Medicine (D.D.M.);
- e. Doctor of Surgical Chiropody (D.S.C.);
- f. Doctor of Podiatric Medicine (D.P.M.);
- g. Doctor of Optometry (O.D.); and
- h. Doctor of Chiropractic (D.C.).

When we are required by law to cover the health care services of any other licensed medical professional under the policy, a physician also includes such other licensed medical professional who: (a) is licensed by the state in which he/she is located; (b) is acting within the lawful scope of his/her license; and (c) provides a health care service which we determine is a covered expense under the policy.

Professional Services: services directly provided to you by a physician of your choice to treat your illness or injury. Such services also include services provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's professional services while the physician is

present in the facility where the service is provided. With respect to such services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising physician or the facility where the service is provided.

Reconstructive Surgery: surgery performed on abnormal structures of the body, caused by congenital defects, development abnormalities, trauma, infection, tumors or disease.

Services: hospital services, professional services, surgical services, maternity services, medical services or any other service directly provided to you by a health care provider, as determined by us.

Single Coverage: means coverage applies only to a covered employee. To be covered, a covered employee must be properly enrolled and approved by us for coverage under the policy. We must also receive timely the appropriate premium to pay for the covered employee's coverage.

Skilled Nursing Care: health care services furnished on a physician's orders which requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of such professional personnel.

Sound Natural Teeth: teeth that: (a) are organic and formed by the natural development of the human body; (b) are not manufactured; (c) have not been extensively restored; (d) have not become extensively decayed or involved in periodontal disease; and (e) are not more susceptible to injury than whole natural teeth.

Standard Plan: the self-insured health plan offered by the State of Wisconsin and administered by a third party through an administrative services only contract.

Surgical Services: an operative procedure performed by a physician and that is recognized by us for the treatment of an illness or injury. Such services include sterilization procedures, preoperative and postoperative care. Such services don't include the reversal of a sterilization procedure, oral surgical services and maternity services.

Totally Disabled/Total Disability: this means you are unable due to illness or injury to perform the essential functions of any full-time job with the policyholder, as determined by us. You are not totally disabled if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. For dependents and retired employees, this means the person's inability due to illness or injury to carry on most of the normal activities of a person of the same age and sex, including, but not limited to, being unable to work on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself, as determined by us. The totally disabled person must be under the regular care of a physician. We have the right to examine such person, including having health care providers examine that person, as often as we reasonably require for us to determine whether or not that person is totally disabled.

Treatment: management and care directly provided to you by a physician or other health care provider for the diagnosis, remedy, therapy, combating, or the combination thereof, of an illness or injury, as determined by us.

We, Us, Our: The EPIC Life Insurance Company.

You, Your: a member.

SECTION III. EFFECTIVE DATE

If application for coverage is properly made on our application form by an eligible employee and the required premium for his/her coverage is submitted in advance to EPIC, the effective date of single or family coverage to be issued under the policy for that eligible employee and his/her eligible dependents, if any, shall be determined by EPIC as follows:

A. Employee

An eligible employee shall become covered under the policy as an insured on the latest of: (1) the policy's policy effective date; or (2) the date he/she becomes eligible, provided the employee applies within 31 days of his/her eligibility date. If the

eligible employee applies more than 31 days following his/her eligibility date, such application will be returned and his/her coverage shall not become effective under the policy.

The eligible employee must be actively at work or on an approved leave of absence and not totally disabled on his/her effective date of coverage under the policy. However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

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B. Dependents

If you apply for family coverage under the policy, each of your eligible dependents shall become insured as a member on the latest of: (1) the date you become covered under the policy as an insured; (2) the date the dependent becomes eligible, provided you apply within 31 days of your dependent's eligibility date. If you apply more than 31 days following your dependent's eligibility date, such application will be returned and that dependent's coverage shall not become effective under the policy. That dependent will be considered a late enrollee and eligible to apply at a later date subject to subsection G. below.

However, if an eligible dependent who would otherwise become insured is confined in a hospital or at home or is totally disabled on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she ceases to be confined in a hospital or at home and is not totally disabled.

If family coverage is in effect on the date of birth of your newborn child or the date you adopt a child, coverage for such child is effective as of that date of birth of the newborn child or, for an adopted child: (1) on the date that a court makes a final order granting your adoption of the child; or (2) on the date that the child is placed for adoption with you, whichever occurs first.

C. Changing From Single Coverage to Family Coverage Due to Marriage

If you have single coverage and wish to change to family coverage to add new eligible dependents because of your marriage, you must apply using our application form and pay the appropriate premium within 31 days of the date of such marriage. If you properly apply within that 31-day period as required by us, the effective date for family coverage will be the date of marriage. If you apply after that 31-day period, such application will be returned and your new dependents will not be covered under the policy. Those dependents will be considered late enrollees and eligible to apply at a later date subject to subsection G. below.

However, if an otherwise eligible dependent is confined in a hospital or at home or is totally disabled on the date his/her coverage would become effective under the policy, his/her coverage shall not be effective until the earliest later date he/she ceases to be confined in a hospital or at home and is not totally disabled.

D. Changing From Single Coverage to Family Coverage Due to a Child's Birth

If you have single coverage, coverage is provided for your newborn natural child from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. Prior to the end of that 60-day period, you must notify us about the child's birth and pay the required premium for that child's coverage during that child's 60-day period. If you fail to notify us and pay the required premium to us, coverage for your newborn natural child shall terminate at the end of that child's 60-day period, unless you apply for limited family or family coverage using our application form as described below.

If you wish to change to family coverage to add your newborn natural child, you must apply using our application form either: (1) within the first 60 days after the birth of your natural child and pay the required premium; or (2) within one year after the birth of your natural child and pay all past-due premiums and in addition pay interest on such premium payments at a rate of 5 1/2% per year. The effective date for such family coverage will be the date of that child's birth.

If you fail to do either (1) or (2) above, your newborn natural child will not be covered under the policy. Your newborn child will be considered late enrollee and eligible to apply at a later date subject to subsection G. below.

E. Changing from Single Coverage to Family Coverage Due to Adoption

If you have single coverage and wish to change to family coverage to add a new eligible dependent because of your adoption of a child or a child placed for adoption, you must apply using our application form and pay the appropriate premium within 60 days of the date of such adoption or placement for adoption. In the case of a child placed for adoption with you, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. If you properly apply within that 60-day period as required by us, the effective date for such family coverage will be: (1) on the date a court makes a final order granting your adoption of the child; or (2) on the date that the child is placed for adoption with you, whichever occurs first. If you apply after that 60-day period, such application will be returned and your new dependent will not be

covered under the policy. Your new dependent will be considered late enrollee and eligible to apply at a later date subject to subsection G. below.

If adoption of a child who is placed for adoption with you is not finalized, the child's coverage will terminate when the child's adoptive placement with you terminates.

F. Adding Dependent Due to Court Order

To the extent required by Section 632.897 (10) (am), Wisconsin Statutes, as amended, if a court orders you with single or family coverage to provide coverage for health care expenses for your dependent child, you will be issued family coverage to include that child effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible for coverage under the policy as determined by us, without that child being subject to our health underwriting requirements, including not having to submit evidence of insurability to us. Written application for that child's coverage must be made by either you, the child's other parent, the department, or the county designee under Section 59.07 (97), Wisconsin Statutes, as amended, using our application form. The completed form, a copy of the court order and the appropriate premium for his/her coverage must be submitted to us as soon as reasonably possible after the court order is issued to you. As long as you are eligible for family coverage under the policy, that child's coverage will continue under the policy until the date that court order is no longer in effect or the date that child has coverage under another group policy or individual policy that provides comparable health care coverage, as applicable, unless that child's coverage ends sooner in accordance with Section IX. When Coverage Ends. You must notify us in writing about that court order ending and/or that other coverage becoming effective for that child as soon as reasonably possible after you become aware of that fact.

G. Late Enrollees

A late enrollee may make written application to us at an approved annual enrollment period. A late enrollee's effective date of coverage under the policy will be January 1st following the approved annual enrollment period.

A late enrollee must apply using our application form and pay the required premium for single or family coverage. Benefits are subject to any waiting periods for pre-existing conditions for late enrollees.

If the late enrollee is an eligible employee, the eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy. However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage, including family coverage for his/her eligible dependents if he/she enrolled such persons, shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

If an eligible employee's or dependent's effective date of regular coverage is deferred under either A. or B. of this Section due to that person being confined, totally disabled or not actively at work, in some cases temporary coverage may nevertheless be provided to the minimum extent required by Section Ins 6.51 (7) (b), Wis. Admin. Code, as amended.

SECTION IV. BENEFIT PROVISIONS

A. Dental Expense Benefit

1. Annual Deductible Amount.

The annual deductible amount is \$200. The deductible amount applies to each member each calendar year. For each member, charges for covered dental expenses covered under a member's policy must add up to the appropriate deductible amount before we pay benefits for other charges for covered expenses. No benefits are payable for charges used to satisfy the appropriate annual deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the appropriate deductible and coinsurance amounts. After the deductible amount for that coverage is satisfied, we'll pay benefits at the coinsurance percentage shown in paragraph 3. for charges for the covered dental expenses incurred by that member, subject to the maximum benefit limits, and payable in excess of a member's Basic Plan benefits.

2. Maximum Benefit Limits.

- a.** The maximum benefit limit for all dental services is \$750 per member per calendar year.
- b.** The orthodontia lifetime maximum benefit limit is \$1,200. This lifetime maximum benefit limit for orthodontia services applies to those dental services incurred by each member for the life of the policy, including renewals, while the member is covered under the policy.

3. Benefits.

We'll pay benefits at 50% of the charges for dental services provided during a calendar year by a legally qualified dentist, orthodontist or dental surgeon for the following dental treatment, services and supplies. Benefits are not payable for any treatment, services or supplies payable under a member's Basic Plan.

- a.** Local anesthesia when provided in conjunction with a covered dental procedure.
- b.** Routine and surgical extractions.
- c.** Therapeutic injections.
- d.** Periodontics, including all diagnoses, surgery and adjunctive services.
- e.** Endodontics.
- f.** Restorations, including fillings of amalgam or synthetic process, but specifically excluding the following: (1) posterior or anterior crowns or jackets; (2) initial placement of full or partial dentures and replacements of dentures and fixed bridge units. Benefits for fillings of synthetic resin on posterior teeth shall be limited to the amount payable for fillings of amalgam.
- g.** Alveolectomy.
- h.** Denture repair and bridge work repair.
- i.** Crowns, provided a tooth cannot be restored by an amalgam or resin filling.
- j.** Orthodontic treatment and appliances involved in the management of birth defects known as cleft lip and cleft palate for a dependent child who is a member up to age 18.
- k.** Inlays and onlays. Benefits are payable only when a tooth cannot be restored by an amalgam filling.
- l.** Prosthetics including bridges and dentures (partial and complete) where chewing function is impaired due to missing teeth. Full dentures are payable only once in a member's lifetime. Partial dentures should be constructed when needed to replace missing teeth. Fixed bridges are a benefit only when the use of removable prosthetic appliance is inadequate.
- m.** Oral surgical services, including related anesthesia. Related x-rays and oral surgical services in connection with the treatment of the temporomandibular joint are not covered under this paragraph.
- n.** Orthodontic services and supplies as follows:
 - (1)** appliances, includes furnishing and attachment of any necessary orthodontic appliances.
 - (2)** Orthodontic treatment performed pursuant to a written treatment plan, including any supporting x-rays, submitted to us within 90 days prior to the commencement of such treatment.

Benefits are payable for charges for covered expenses incurred for any one course of orthodontic treatment, including any orthodontic diagnosis, evaluation and pre-orthodontic treatment. Orthodontic services and supplies are not payable until a member has been covered under the policy for 12 calendar months.

- o.** Dental implants.

In all cases where a patient selects a more expensive service or benefit than is customarily provided, EPIC will pay the applicable percentage of the fee for the service that would be adequate to restore the tooth or dental arch to contour and function. The patient is then responsible for the remainder of the dentist's fee.

4. Exclusions.

The general exclusions stated in Section VI. of the policy apply to the dental expense benefits of the policy. In addition, the following aren't covered under the policy. The policy provides no benefits for:

- a.** Dental services incurred for the replacement of a full upper or a full lower denture regardless of cause after we have included the charge for such denture(s) at least once in considering benefits under this or a similar dental expense benefit provision.
- b.** Dental services incurred for relining of dentures.
- c.** Dental services incurred during the first 12 calendar months following a member's effective date of coverage if that member was a late applicant.
- d.** Orthodontia services administered in furtherance of a treatment plan unless the initial appliance in that plan was inserted prior to age 19. Consideration of payment for orthodontia services, regardless when billed or paid, shall be applied only to the calendar year during which the actual service was provided. If orthodontia charges are not itemized and billed as the services are provided but billed as a single charge, the initial appliance charge shall apply to the calendar month of insertion of the appliance. The remaining charge shall be considered to be for services provided over the period of time established by the orthodontist as the period of treatment and prorated equally over that period of time.
- e.** Dental services that are not dentally necessary or not required in accordance with accepted dental practices.
- f.** Diagnostic and preventive dental services including, but not limited to, dental examinations, regular and periodontal cleaning, fluoride, x-rays, sealants, and emergency evaluations.
- g.** Orthodontic services and supplies incurred during the first 12 calendar months following a member's effective date of coverage under the policy.
- h.** Dental services not specifically identified paragraph 3. above as being covered under the policy.
- i.** Dental services and supplies for cosmetic purposes, unless necessitated as a result of injuries sustained while the member is covered under the policy.
- j.** Dental services and supplies provided in connection with the treatment of the temporomandibular joint.

B. Excess Major Medical Expense Benefits

1. Deductible.

The annual deductible amount is \$250 per member, not to exceed \$500 per family. The annual deductible amount applies each calendar year. Charges for covered expenses for health care services must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. No benefits are payable for the charges used to satisfy a member's deductible amount. You are responsible for paying the charges used to satisfy the appropriate deductible amount.

2. **Payment of Benefits.**

Subject to any applicable deductible, we'll pay benefits at 100% of the charges for covered expenses a member incurs in connection with:

- a. a physical illness or injury that causes a member's confinement in a hospital that occurred while you are covered under the policy; or
- b. a physical illness or injury that causes treatment of the member as a surgical patient at a duly licensed surgical or hospital outpatient treatment center while you are covered under the policy.

The requirements of a. and b. above do not apply to paragraphs 5., 6., 7., 8., 10., 11., 12., 13., and 14 below.

Benefits are not payable for: (a) any physical illness or injury other than as stated in a. and b. above, except as specifically stated in paragraphs 5., 6., 7., 8., 10., 11., 12., 13., and 14 below; (b) charges paid under a members Basic Plan; and (c) any charges incurred prior to a hospital confinement or surgery as stated above.

Covered expenses must be incurred while the member is covered under the policy. The applicable deductible must be satisfied before benefits are payable, unless specifically stated otherwise in the policy.

3. **Covered Expenses.**

The health care services described in paragraphs 4. through 14. are covered expenses, provided they were covered or would have been covered under a members Basic Plan. All health care services must be medically necessary except for services for nervous or mental disorders. All health care services must be ordered by a physician because of a covered illness or injury. If the health care service is not listed in this paragraph, that health care service is not covered and benefits are not payable under the policy. Benefits are not payable for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see Section VI. Exclusions.

4. **Treatment of a Physical Illness or Injury.**

Benefits are payable for all health care services covered under this paragraph 4. up to a maximum of \$250,000 for the lifetime of the member while the member is covered under the policy.

We'll pay benefits for charges for the following health care services related to: (a) a physical illness or injury that causes a member's confinement in a hospital that occurred while you are covered under the policy; or (b) a physical illness or injury that causes treatment of the member as a surgical patient at a duly licensed surgical or hospital outpatient treatment center while you are covered under the policy. Benefits are not payable for any physical illness or injury other than as stated in (a) and (b) above.

We'll treat simultaneous or successive health conditions as one physical illness or injury or periods of one physical illness or injury if there's any reasonable amount of medical evidence, as determined by us, that such conditions are due to the same or related causes.

- a. **Professional Services.** We'll pay benefits for charges for the following professional services for one illness or injury. These don't include services for the treatment of alcoholism, drug abuse or nervous or mental disorders or services for bone marrow, heart, heart/lung, liver, lung, pancreas or kidney transplants. Please see Section IV. B. 5. Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders, IV. B. 6. Treatment of Kidney Disease and IV. B. 9. Organ Transplants.

- (1) Surgical services, other than oral surgical services.

Benefits are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by us, only as follows. If we determine benefits are payable for the services directly provided to you by a surgical assistant: (a) benefits for the covered services of a physician surgical assistant will be paid up to a maximum of 25% of the charge we determine for that surgical procedure performed by the physician; and (b) benefits for the covered services of a

surgical assistant who is not a physician will be paid up to a maximum of 10% of the charge we determine for that surgical procedure performed by the physician.

Benefits payable for covered bilateral surgical procedures done at the same setting are limited to a maximum of one and one-half times the charge we determine for the single surgical procedure. No additional benefits are payable for those procedures. A bilateral surgical procedure is the same surgical or invasive medical procedure performed on similar anatomical parts which are on opposite sides of a body which are usually identified as either right or left (e.g. eyes, ears, arms, legs, hands, feet, breasts, lungs or kidneys).

Benefits payable for covered multiple surgical procedures, other than bilateral surgical procedures, are limited to a maximum of 100% of the charge we determine for the primary surgical procedure and 50% of the charge we determine for each additional procedure, other than procedures determined to be incidental or inclusive. A primary surgical procedure is the surgical procedure with the highest charge as determined by us. Multiple surgical procedures are more than one surgical or invasive medical procedure performed at the same setting, usually within the same related anatomical region, or same incision area.

Benefits are not payable for incidental surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest charge as determined by us and which, in our opinion, are not clearly identified and/or do not add significant time or complexity to the surgical session. Benefits payable for incidental surgical procedures are limited to the charge for the primary surgical procedure with the highest charge, as determined by us. No additional benefits are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., benefits are payable for the hysterectomy, but not for the removal of the appendix).

- (2) Medical services for a physical illness or injury, including second opinions. Services must be provided: (a) in a hospital; (b) in a physician's office; (c) in an urgent care center; (d) in a surgical care center; or (e) in your home. These services do not include home care services covered under paragraph 11. of this subsection.
- (3) Anesthesia services related to injury, surgical or maternity services which are covered under the policy.
- (4) Diagnostic radiology and laboratory services directly provided to you for radiology and lab tests related to covered physical illness or injury.
- (5) Maternity services. An abortion procedure for the termination of a mother's pregnancy is covered only if the pregnancy is considered a life-threatening complication of the mother's existing physical illness and the abortion procedure is permitted by, and performed in accordance with, law.
- (6) Radiation therapy and chemotherapy services for therapeutic treatment of covered benign or malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

- b. Hospital Services.** We'll pay benefits for charges for the following hospital services for one illness or injury. These don't include services for the treatment of alcoholism, drug abuse or nervous or mental disorders or services for bone marrow, heart, heart/lung, liver, lung, pancreas or kidney transplants. Please see Section IV. B. 5. Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders, IV. B. 6 Treatment of Kidney Disease and IV. B. 9. Organ Transplants.

Inpatient hospital services for a physical illness or injury:

- (1) Charges for room and board for occupancy of a private room, semiprivate room or lesser accommodations;
- (2) Nursing services;
- (3) Charges for miscellaneous hospital expenses; and
- (4) Charges for intensive care unit room and board.

With respect to confinements for pregnancy, the policy shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for cesarean delivery. However, you are free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

c. Other Health Care Services We Cover. We'll pay benefits for charges for the following health care services for a physical illness or injury following an outpatient surgical procedure or confinement:

- (1) Outpatient physical, speech, occupational and respiratory therapy. The therapy must be expected to significantly improve your physical condition within 60 days of the date on which such treatment begins. The therapy must be performed by a physician, licensed physical, speech, occupational or respiratory therapist, or any other health care provider approved by us. The therapist or other health care provider must be providing the therapy under the direction of your physician. If a license to perform such therapy is required by law, that therapist or other health care provider must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for your temporomandibular joint disorder is not covered under this paragraph c. (1).
- (2) Licensed professional ambulance services for emergency medical care and transportation to the nearest hospital where appropriate medical care is available. Transportation undertaken to secure treatment by a personal physician or by a physician or institution of greater renown or greater specialization is not covered.
- (3) Blood and blood plasma.
- (4) Initial artificial limbs and eyes.
- (5) Casts; splints; strapping; orthopedic braces and crutches. These don't include orthotics, special shoes, or devices to protect the feet unless the device is a permanent part of an orthopedic leg brace.
- (6) Oxygen; rental of, or at our option, purchase of equipment to administer oxygen and respiratory therapy equipment.
- (7) Medical supplies prescribed by a physician.
- (8) Rental of or, at our option, purchase of durable medical equipment such as, but not limited to: wheelchairs; hospital type beds; and artificial respiration equipment. Coverage for such equipment and devices will be limited to the standard models as determined by us. We'll pay benefits for only the standard models. You are responsible for paying any amount in excess of the charge for the standard models. When the durable medical equipment is purchased, benefits are payable for subsequent repairs necessary to restore the durable medical equipment to a serviceable condition. If the durable medical equipment is rented, we'll pay benefits for charges up to the purchase price of that durable medical equipment. Rental fees exceeding the purchase price, routine periodic maintenance, and replacement of batteries are not covered. The durable medical equipment must be prescribed by the physician.

- (9) Nursing services for skilled private duty nursing provided by a registered nurse or practical nurse provided that such practical nurse is licensed by the state in which the service is performed. Such services must be ordered by the attending physician. Benefits are payable up to a maximum of \$10,000 for any one physical illness or injury.
- (10) Prescription legend drugs. Prescription legend drugs are any medicine, including investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, for which the Federal Food, Drug and Cosmetic Act, as amended, requires its label to contain the wording "Caution: Federal Law prohibits dispensing without prescription" or similar wording.
- (11) Dental repair of your sound natural teeth due to that member's injury, including the replacement of such teeth (but not including damage to or the replacement of fillings, braces, bridgework or artificial dentures). Treatment must be provided within 180 days of the injury.
- (12) Breast reconstruction of the affected tissue following a mastectomy. Benefits are also payable for charges for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.
- (13) Hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a member in a hospital or ambulatory surgery center provided: (1) the member is a child under the age of five; (2) the member has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following area of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (3) the member has a medical condition that requires hospitalization or general anesthesia for dental care.

5. Alcoholism, Drug Abuse and Nervous or Mental Disorders.

- a. **Definitions.** The following definitions apply to this paragraph 5. only:

Collateral: a member of your immediate family.

Day Treatment Programs: nonresidential programs for alcohol and drug dependent members, which are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities, that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

Hospital: (1) a hospital licensed under Section 50.35, Wisconsin Statutes; (2) an approved private treatment facility as defined in Section 51.45 (2) (b), Wisconsin Statutes, as amended; or (3) an approved public treatment facility as defined in Section 51.45 (2)(c), Wisconsin Statutes, as amended.

Inpatient Hospital Services: (1) services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to a member who is a bed patient in the hospital; and (2) services for the treatment of alcoholism or drug abuse that are directly provided to a member in a facility with a program certified by the Department under Section HSS 61.63, Wis. Adm. Code, as amended.

Outpatient Services: nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems directly provided to you and, if for the purpose of enhancing your treatment, a collateral by any of the following: (1) a program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended; (2) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; or (3) a licensed psychologist who is listed in the national register of health service providers in psychology or who is certified by the American board of professional psychology.

Residential Treatment Programs: therapeutic programs for alcohol and drug dependent members including therapeutic communities and transitional facilities.

Transitional Treatment Arrangements: services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to you in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, if both the program and the facility are approved by the Department as defined in the Section Ins 3.37, Wis. Adm. Code, as amended. Such transitional treatment is limited to: (1) mental health services for adults in a day treatment program offered by a provider certified by the Department under Section HSS 61.75, Wis. Adm. Code, as amended; (2) mental health services for children and adolescents in a day treatment program offered by a provider certified by the Department under the Section HSS 61.81, Wis. Adm. Code, as amended; (3) services for persons with chronic mental illness provided through a community support program certified by the Department under Section HSS 63.03, Wis. Adm. Code, as amended; (4) residential treatment programs for alcohol and drug dependent persons certified by the Department under Section HSS 61.60, Wis. Adm. Code, as amended; (5) services for alcoholism and other drug problems provided in a day treatment program certified by the Department under Section HSS 61.61, Wis. Adm. Code, as amended; (6) intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine; and (7) out-of-state services and programs that are substantially similar to (1), (2), (3), (4) and (5) if the provider is in compliance with similar requirements of the state in which the health care provider is located.

b. Benefits. We'll pay benefits for charges as stated below. The annual deductible amount does not apply to this paragraph 5.

- (1) **Inpatient Hospital Services.** Each calendar year, benefits are payable at 100% of the charges for covered expenses incurred by a member in that calendar year for inpatient hospital services provided to you up to the lesser of the charges for the first 30 days of your confinement in a hospital, or the first \$7,000 in charges for such services in each calendar year. This maximum applies to the total benefits payable under this paragraph together with benefits that are payable under a member's Basic Plan.
- (2) **Outpatient Services.** Each calendar year, benefits are payable at 100% for the first \$2,000 of charges for covered expenses incurred by you in that calendar year for outpatient services provided to you. This maximum applies to the total benefits payable under this paragraph together with benefits that are payable under a member's Basic Plan.
- (3) **Transitional Treatment Arrangements.** Each calendar year, benefits are payable at 100% of the first \$3,000 of charges for covered expenses incurred by you in that calendar year for transitional treatment arrangements provided to you. This maximum applies to the total benefits payable under this paragraph together with benefits that are payable under a member's Basic Plan.

The criteria that we use to evaluate a transitional treatment program or service to determine whether it is medically necessary and covered under the policy include, but are not limited to, whether:

- (a) the program is certified by the Department;
- (b) the program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
- (c) the specific diagnosis is consistent with the symptoms;
- (d) the treatment is standard medical practice and appropriate for the specific diagnosis;
- (e) the treatment plan is focused for the specific diagnosis;

- (f) the multidisciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the service is provided.

We will need the following information from the health care provider to help determine the medical necessity of such program or service:

- (a) a summary of the development of the member's illness and previous treatment;
- (b) a well-defined treatment plan listing treatment objectives, goals and duration of the care provided under the transitional treatment arrangement program; and
- (c) a list of credentials for the staff who participated in the transitional treatment arrangement program or service, unless the program or service is certified by the Department.

The annual maximum is \$7,000 per member per calendar year. This maximum applies to the total benefits payable under (1), (2) and (3) above together with benefits payable under a member's Basic Plan.

Benefits payable under this paragraph 5. combined with a member's Basic Plan shall not exceed \$7,000 per member per calendar year.

No benefits are payable for charges for outpatient services provided to or received by a member as a collateral of a patient which do not enhance the outpatient treatment of another member under the Plan.

Except as stated in this paragraph 5. no other benefits for alcoholism, drug abuse and nervous or mental disorders are payable under the policy.

6. Treatment of Kidney Disease.

We'll pay benefits for charges for the treatment of kidney disease limited to the following:

- a. Hospital, surgical and all other medically necessary medical expenses which are incurred in the treatment of kidney disease. Such treatment of a member may be provided: (1) while the member is hospital confined; or (2) in the outpatient department of a hospital; or (3) in the member's home. Such expenses may also include the rental or, at our option, purchase of kidney dialysis equipment.
- b. Hospital, surgical and all other medically necessary medical expenses which are incurred due to a kidney transplant operation or related to an artificial kidney.
- c. Medical expenses which are incurred by a potential living donor who is related to the member. Such expenses would include the expense for evaluation, surgery and post-operative follow-up.
- d. Expenses which are incurred with respect to cadaveric donor kidneys which are used in a transplant operation for the member. Such expenses include the procurement, transportation and the preservation of the kidneys.

Total benefits payable under a. through d. above shall not exceed \$30,000 per member per calendar year.

Except as stated in this paragraph 6. no other benefits for the treatment of kidney disease are payable under the policy. The deductible amount does not apply to this paragraph 6.

7. Mammograms and Pap Smears.

Mammograms and pap smears must be performed by or under the direction of a physician or licensed nurse practitioner. We'll pay benefits for charges for the following:

- a. one routine examination by low-dose mammography of a female member per calendar year;

b. routine taking and reading of pap smear or routine papanicolaou smear.

8. Equipment and Supplies for Treatment of Diabetes.

We'll pay benefits for charges incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies, including insulin, used in the treatment of diabetes. This benefit is limited to the purchase of one pump per member per calendar year. You must use the pump for at least 30 days before the pump is purchased. We'll also pay benefits for charges for diabetic self-management education programs.

9. Organ Transplants.

We'll pay benefits for charges for the following organ transplants: heart; lung; heart/lung; pancreas; liver; and bone marrow.

We'll pay benefits for charges for up to one-half of the covered charges for such organ transplant not to exceed \$30,000 per member for all such organ transplants. Benefits are not payable for the transplant of an artificial organ or ventricular assist device. Cornea transplants will be considered as an illness and not an organ transplant.

Except as stated in this paragraph 9, no other benefits for organ transplants, other than kidney transplants, are payable under the policy. Kidney transplants are payable under paragraph 6.

10. Skilled Nursing Care in a Licensed Skilled Nursing Facility.

We'll pay benefits for charges for skilled nursing care you receive in a licensed skilled nursing facility as follows. We'll do so if: (a) you are admitted to a licensed skilled nursing facility within 24 hours after discharge from a hospital; and (b) it's for continued treatment of the same illness or injury treated in the hospital. We'll pay the maximum daily room rate established for skilled nursing care in that facility by the Department for purposes of reimbursement under the Medical Assistance Program under Sections 49.45 to 49.47, Wisconsin Statutes, as amended. We'll pay benefits for such care at that facility for up to 30 days of confinement for that member. Benefits are payable only for the skilled nursing care which continues to treat the same illness or injury for which you had been treated at the hospital prior to your admission to that skilled nursing facility. Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending physician and is recertified as medically necessary every seven days and is not essentially domiciliary or custodial care. No benefits are payable for domiciliary care, maintenance care, supportive care, custodial care, or for care which is available at no cost to you or provided under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes, as amended).

11. Home Care Services.

a. **Covered Services.** This paragraph 11. applies only if charges for home care services are not covered elsewhere under the policy. A Department-licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. You should make sure the agency meets this requirement before services are provided. We'll pay benefits for charges for the following services:

- (1) Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
- (2) Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
- (3) Physical or occupational therapy or speech-language pathology or respiratory care;
- (4) Medical supplies, drugs and medications prescribed by a physician; laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;
- (5) Nutrition counseling provided or supervised by a registered or certified dietician; and

- (6) Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending physician must request or approve this evaluation.

b. Limits on Home Care Services.

- (1) Home care isn't covered unless your attending physician certifies that: (a) hospitalization or confinement in a licensed skilled nursing facility would be needed if you didn't have home care; and (b) members of your immediate family, or others living with you, couldn't give you the care and treatment you need without undue hardship.
- (2) If you were hospitalized just before home care started, your primary physician during your hospital stay must also approve the home care plan.
- (3) We'll pay benefits for charges for up to 40 home care visits in any 12-month period per member. Each visit by a person providing services under a home care plan, evaluating your need, or developing a plan counts as one visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.
- (4) If home care is covered under two or more health insurance contracts or plans, coverage is payable under only one of them, except as stated in Section VIII. Coordination of Benefits.
- (5) The maximum weekly benefit payable for this coverage won't be more than the benefits payable for the total weekly charges for skilled nursing care available in a licensed skilled nursing facility, as determined by us.

12. Blood Lead Tests.

We'll pay benefits for charges for blood lead tests for members age five and under.

13. Temporomandibular Joint Disorders (TMJ).

a. Benefits. We'll pay benefits for charges for the following:

- (1) oral surgical services, including anesthesia services for surgical correction of your temporomandibular joint disorder (TMJ), including arthroscopy, arthrotomy, meniscectomy, condylectomy, coronoidectomy, excision of, and reduction for dislocation of, the temporomandibular joint;
- (2) health care services, other than those stated in (1) above, for your temporomandibular joint disorders (TMJ Syndrome), up to a maximum benefit limit of \$1,250 per member per calendar year. This maximum applies to the total benefits payable under this paragraph together with benefits that are payable under a member's Basic Plan. Such health care services must not permanently alter the teeth or bite and include: (a) history, exam and diagnosis; (b) diagnostic services, such as but not limited to: x-rays, magnetic resonance imaging (MRI) and computed tomography (CT) scans; (c) splinting and adjustments, including, muscle relaxation appliances; anterior repositioning appliances; and pivotal appliances; (d) rental of, or at our option, purchase of a transcutaneous nerve stimulation (TENS) unit; (e) biofeedback; and (f) physical therapy.

No other coverage for your temporomandibular joint disorder is available under the policy.

b. Exclusions. The following aren't covered under this paragraph 13. The policy provides no benefits for:

- (1) dental treatment, services and supplies for temporomandibular joint disorder which permanently alter the teeth or bite, including but are not limited to: orthodontics; restorative crowns; and bridgework;
- (2) behavioral modification;

- (3) postural training;
- (4) hypnosis therapy; or
- (5) health care services not covered under the policy. Please see Section VI. Exclusions.

14. Immunizations.

We'll pay benefits at 100% for charges for immunizations including, but not limited to the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella. Immunizations for travel purposes are not covered.

C. Accidental Death and Dismemberment

1. Benefits.

If as a result of bodily injury a member shall suffer, directly and independently of all other causes and within 90 days of the injury, any of the losses described below, benefits are payable as follows:

- a.** with respect to you, for loss of life, both hands or both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye or one foot and sight of one eye, we'll pay \$5,000;
- b.** with respect to your spouse who is a member, for loss of life, both hands or both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye or one foot and sight of one eye, we'll pay \$2,500;
- c.** with respect to your dependent child who is a member, for loss of life, both hands or both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye or one foot and sight of one eye, we'll pay \$1,000;
- d.** for loss of one hand or one foot or sight of one eye, we'll pay one-half of the amounts stated above.

With respect to hands and feet, "loss" shall mean the continued severance at or above the wrist or ankle joints; with respect to eyes, the entire and irrecoverable loss of sight.

If a member sustains more than one of the losses stated above as a result of the same injury, the total payable for such losses shall be limited to the amounts stated in a. through d. above.

Payment for the loss of your life shall be made to the beneficiary as appears on our records, if surviving, otherwise to your estate. Benefits for any other loss shall be paid to you.

You may change the beneficiary by filing written notice on a form approved by us. The changes shall be effective when entered on our records. Beneficiary's consent is not needed.

2. Exclusions.

The general exclusions stated in Section VI. apply to the accidental death and dismemberment expense benefits of the policy. In addition, the following aren't covered under the policy. The policy provides no benefits for any loss due to:

- a.** injury you receive while operating, riding in or descending from any aircraft, except as a fare-paying passenger in a commercial aircraft on a regularly scheduled flight;
- b.** sickness or disease;
- c.** bacterial infections (unless due to accidental food poisoning);
- d.** injury sustained while intoxicated;

- e. injury sustained while under the influence of any controlled substance unless prescribed by and taken under the direction of a physician;
- f. an intentionally self-inflicted injury or illness, suicide or attempted suicide, whether a member is sane or insane;
- g. your participation in a riot or in the commission of a crime.

SECTION V. WAITING PERIOD FOR PRE-EXISTING CONDITIONS

This section applies to members who apply during an approved open enrollment period only. This section does not apply to members who apply when first eligible for coverage under the policy.

Within 12 months prior to a member's effective date of coverage under the policy, he/she may have: (a) had an illness or injury diagnosed; (b) received care, medical services or treatment for an illness or injury; or (c) had symptoms of an illness or injury which would cause a reasonably prudent person to seek diagnosis, care, medical services or treatment. If so, benefits are not payable for expenses incurred as a result of that illness or injury and any complications of any such illness or injury until the member has been insured under the policy for 180 calendar days. No benefits are payable for charges for treatment, services, supplies or other expenses incurred during the waiting period for any such illness or injury and any complications of any such illness or injury. Charges for covered expenses for treatment of a pre-existing illness or injury and any complications of any such illness or injury which are incurred after the expiration of the waiting period for it are eligible for benefits as provided under the policy.

If a dependent child is born or is legally adopted by the insured while he/she has family coverage under the policy, the child doesn't have a waiting period for any such illness or injury.

SECTION VI. EXCLUSIONS

The following aren't covered under the policy. The policy provides no benefits for:

- A. Treatment, services and supplies for any illness or injury arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under workers' compensation or similar laws have been claimed, paid, waived or compromised or whether you're covered under worker's compensation insurance.
- B. Health care services furnished by the U.S. Veterans Administration, except for such health care services for which under applicable federal law the policy is the primary payor and the U.S. Veterans Administration is the secondary payor.
- C. Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless coverage is required by any state or federal law.
- D. Health care services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile.
- E. Cosmetic treatment or surgery.
- F. Reconstructive surgery, except for such surgery required: (1) to repair a significant defect caused by an injury; (2) to repair a defect caused by congenital anomaly causing a functional impairment of a dependent child; (3) incidental to a mastectomy; or (4) due to a physical illness.
- G. Health care services which aren't medically necessary for the treatment of an illness or injury, as determined by us.

- H.** Medical exams, including eye exams and hearing exams, health assessments, procedures and associated services requested by a third party. Such exams include, but are not limited to: (1) exams for insurance, school, employment or camp; or (2) exams directed or requested by a court of law, except for court ordered nervous or mental disorder exams to the extent benefits are payable under Section IV. B. 5. Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders.
- I.** Preparation, fitting or purchase of eyeglasses or contact lenses; or vision therapy; eye refractive surgery or hearing aids.
- J.** Health care services provided at any nursing facility or convalescent home or expense in any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in Section IV. B. 5. Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders.
- K.** Health care services provided by members of a member's immediate family or anyone else living with him/her.
- L.** Custodial care or rest care.
- M.** Health care services which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended.
- N.** Medical supplies and durable medical equipment for your comfort, personal hygiene or convenience including, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.
- O.** Health care services for, or leading to, sex transformation surgery, the sex transformation surgery, and sex hormones related to such surgery.
- P.** Reversal of sterilization.
- Q.** Therapy services such as recreational, educational therapy, physical fitness, or exercise programs, except as specifically stated in Section IV. B. 4. c. (1).
- R.** Artificial insemination or fertilization methods including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
- S.** Health care services not specifically identified as being covered under the policy.
- T.** Professional services not provided by a physician or any of the health care providers listed in the definition of Professional Services in Section II. Definitions.
- U.** Health care services provided: (1) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (2) in the cutting, trimming or other non-operative partial removal of toenails; (3) in connection with any of those specified in (1) and (2).
- V.** Abortion procedures for the termination of pregnancy, except as specifically stated in Section IV. B. 4. a. (5).
- W.** Health care services provided when your coverage was not effective under the policy. This includes health care services provided either prior to your effective date of coverage or after your coverage terminated under the policy, except as stated in Section VII. Extension of Benefits. Please see Section IX. When Coverage Ends.
- X.** Health education, marriage counseling, holistic medicine, or other programs with an objective to provide complete personal fulfillment.
- Y.** Health care services provided to or received by a member as a collateral in connection with treatment of any person who is not a member under this certificate.
- Z.** Housekeeping, shopping or meal preparation services.

- AA.** Food received on an outpatient basis, food supplements, or vitamins.
- BB.** Health care services for obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology, as determined by us.
- CC.** Retin-A, Minoxidil, Rogaine, or their medical equivalent in the topical application form, unless medically necessary.
- DD.** Health care services used in educational training or vocational training.
- EE.** Health care services provided in connection with: (1) any illness or injury caused by you engaging in an illegal occupation; or (2) any illness or injury caused by your commission of, or an attempt to commit, a felony.
- FF.** Room, board, services and supplies that are furnished to you by a hospital on the Friday and Saturday of the weekend of hospital admission if you are admitted as a registered resident patient to the hospital on one of those days, unless your hospital admission is medically necessary or such admission is required to provide you with emergency medical care of a covered illness or injury.
- GG.** Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.
- HH.** Health care services provided in connection with a health care service not covered under the policy. An example would be inpatient hospital services in connection with a health care service not covered under the policy.
- II.** That portion of the amount billed for a health care service covered under the policy that exceeds our determination of the charge for such health care service.
- JJ.** Health care services for which you have no obligation to pay.
- KK.** Health care services for which proof of claim isn't provided to us in accordance with Section XI. H. Proof of Claim.
- LL.** Health care services and prescription legend drugs provided in connection with alcoholism, drug abuse and nervous or mental disorders, except as specifically stated in Section IV. B. 5.
- MM.** Health care services not for or related to an illness or injury, other than as specifically stated in the policy.
- NN.** Health care services: (1) paid or payable by a Basic Plan; (2) that would have been payable by the Standard Plan including Medicare and State Medicare Plus \$100,000 in cases where you and any eligible dependents are not enrolled in a Basic Plan.
- OO.** Health care services that would have been payable by the Standard Plan in cases where coverage for alcoholism, drug abuse and nervous or mental disorders are denied by a Basic Plan due to utilization of non-preferred provider, self referral or services obtained outside the plan area.
- PP.** Health care services that are denied by a Basic Plan due to lack of properly approved referral, authorization or certification.
- QQ.** Health care services, devices or procedures for which coverage is denied under a Basic Plan, except for benefits denied under the Basic Plan because a covered employee exhausted the applicable Basic Plan maximum.
- RR.** Dental treatment, services and supplies, including oral surgical services, except as specifically stated in Section IV. A.
- SS.** Health care services received prior to a hospital confinement or surgery.

SECTION VII. EXTENSION OF BENEFITS

Our liability with respect to any established illness or injury shall be limited to the payment of charges incurred prior to the date of termination of eligibility for reasons other than termination of the policy by the policyholder, except as provided below:

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Benefits for an established illness or injury shall continue uninterrupted through a period of total disability experienced by a member but shall not extend beyond the date the member becomes insured under any other policy issued by any other insurer, association or service organization, for benefits of a type similar to major medical expense benefits. However, our liability during the period of total disability plus that previously allowed shall not exceed an aggregate of 12 months in time or an aggregate of benefits in excess of the maximum benefit of the policy which would have been allowable in the absence of termination of eligibility.

This section only applies when the policy is not replaced by another group health insurance policy, group health plan, or self-insured group health benefits plan and Section Ins 6.51 (6) and (7), Wisconsin Administrative Code, as amended, requires that an extension of coverage be provided under the policy by us to an insured or dependent who is eligible under that administrative rule for an extension of benefits, including that person meeting the requirements set forth in this section as determined by us.

SECTION VIII. COORDINATION OF BENEFITS (COB)

A. Applicability

1. This section only applies to Section IV. A. and B. and applies to this plan when a covered employee or the covered employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.
2. If this section applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:
 - a. shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
 - b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in subsection D. Effect on the Benefits of This Plan.

B. Definitions

1. **Allowable Expense:** a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

2. **Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this section or a similar provision takes effect.
3. **Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include Medicare and Medicaid. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

- c. Medical expense benefits coverage in group, group-type and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under a., b. or c. above is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- 4. **Primary Plan/Secondary Plan:** Subsection C. Order of Benefit Determination Rules states whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

- 5. **This Plan:** the part of the policy that provides benefits for health care expenses.

C. Order of Benefit Determination Rules

1. General.

- a. For benefits described in Section IV. B., when there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan.
- b. For all other benefits described in the policy, except for those described in Section IV. B., when there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:
 - (1) the other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of this plan; and
 - (2) both those rules and this plan's rules described in subsection C. 2. require that this plan's benefits be determined before those of the other plan.

- 2. **Rules.** This plan determines its order of benefits using the first of the following rules which applies:

- a. **Non-dependent/Dependent.** The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent of an employee, member or subscriber.
- b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subsection C. 2. c., when this plan and another plan cover the same child as a dependent of different persons, called "parents":
 - (1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
 - (2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (1) but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (1) first, the plan of the parent with custody of the child;
- (2) then, the plan of the spouse of the parent with custody of the child; and
- (3) finally, the plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C. 2. b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph d.

e. Continuation Coverage.

- (1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:
 - (a) first, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber;
 - (b) second, the benefits under the continuation coverage.
- (2) If the other plan does not have the rule described in subparagraph (1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

D. Effect on the Benefits of This Plan

1. When This Subsection Applies.

This subsection applies when, in accordance with subsection C. Order of Benefit Determination Rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in 2. below.

2. Reduction in This Plan's Benefits.

The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

- a. the benefits that would be payable for the allowable expenses under this plan in the absence of this section; and
- b. the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made. Under this provision, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

E. Right to Receive and Release Needed Information

EPIC has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give EPIC any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, EPIC may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. EPIC will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by EPIC is more than it should have paid under this section, it may recover the excess from one or more of:

- 1. the persons it has paid or for whom we have paid;
- 2. insurance companies; or
- 3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION IX. WHEN COVERAGE ENDS

As determined by us, your coverage under the policy shall end automatically without notice on the earliest of the following dates:

- A. The date the policy terminates;
- B. The date you die;
- C. The date you reach your lifetime maximum benefit limit;

- D.** The day immediately following the last day of the calendar month for which the premium required for your coverage has been paid to us in accordance with the policy;
- E.** The day immediately following the last day of the calendar month in which you retiree or lose eligibility. You may be eligible to continue coverage under the policy as an annuitant as determined by your employer.
- F.** For a covered employee's dependent who is a member, the date the covered employee's coverage terminates;
- G.** For a covered employee's spouse who is a member, the date the covered employee's spouse is no longer married to the covered employee due to divorce or annulment;
- H.** For a dependent child who is a member, the earliest of the following dates:
 1. The date the child marries or acquires comparable group coverage from us as a covered employee;
 2. The day immediately following the last day of the calendar year in which the child provides 50% or more of his/her own support, as determined by us;
 3. The day immediately following the last day of the calendar year the child reaches age 19, if he/she is not a full-time student;
 4. The day immediately following the last day of the calendar year the child no longer attends school as a full-time student;
 5. The day immediately following the last day of the calendar year the dependent student reaches age 25;
 6. The day immediately following the last day of the calendar year in which the child ceases to be an eligible dependent, as determined by us.

If you have family coverage under the policy, a dependent child who is a mentally retarded or physically handicapped may continue coverage under your family coverage beyond age 19 as set forth in the definition of "Dependent" in Section II.

- I.** For a child of a dependent child who is a member, the date the dependent child reaches age 18.

SECTION X. CONTINUATION COVERAGE PRIVILEGE

A. Wisconsin Law

In certain cases you may be eligible to continue your terminated coverage which would otherwise end under Section IX. When Coverage Ends in accordance with Section 632.897, Wisconsin Statutes, as amended. Those eligible for continuation coverage are: (1) a covered employee who is no longer eligible for coverage under the policy through the policyholder, except if his/her employment is terminated for misconduct; or (2) a covered employee's spouse or dependent who is no longer eligible for coverage under the policy through the policyholder due to divorce, annulment or death of the covered employee. In either case, you must be covered under the policy through the policyholder for at least three months immediately prior to the termination date of your coverage.

Within five days of the policyholder's receiving notice to end your coverage or notice that you are eligible under (1) or (2) above, the policyholder must notify you of:

1. Your option to continue your coverage under this subsection;
2. The premium amount you must pay monthly to continue your coverage. The premium amount for continuation coverage will be at the premium rate that we require for such coverage.

3. The manner in which and the place to which you must make premium payments; and
4. The time by which you must pay the premiums required for continuation coverage.

If you are eligible to purchase continuation coverage under Section 632.897, Wisconsin Statutes, and timely elect to continue your coverage and pay to the policyholder the required premium within 30 days after receiving the notice described above from the policyholder, the policyholder must notify us of your election of continuation coverage as soon as reasonably possible in the manner required by us. Your continuation coverage under the policy may be continued until the earliest of the following dates:

1. The date you become eligible for other similar group health care coverage or the same coverage under the policy;
2. For a covered employee's spouse, the date the covered employee is no longer eligible for coverage under the policy;
3. The date the policy terminates;
4. The end of the last coverage period for which you paid the required premium; or
5. The end of 36 consecutive months after you elect continuation coverage.

If any of the five events described above applies to a member with continuation coverage, the member whose continuation coverage terminated under the policy due to that event must give written notice of that event to the policyholder and us as soon as reasonably possible. The policyholder must also notify us of that event as soon as reasonably possible after becoming aware of that event.

B. Federal Law

A member who is no longer eligible for coverage under the policy, such as a member whose employment ends with the policyholder, certain dependent children, or a divorced or surviving spouse and his/her children, may be eligible for continuation coverage in accordance with the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended. If the member is eligible for continuation coverage under COBRA, please see the policyholder for further information.

SECTION XI. GENERAL PROVISIONS

A. Your Relationship with Your Physician, Hospital or Other Health Care Provider

We won't interfere with the professional relationship you have with your physician, hospital or other health care provider. We don't contract with you to choose or provide a physician, hospital or other health care provider or services or facilities; nor do we assure their availability. We're not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any physician, hospital or other health care provider, including, but not limited to, any network provider or preferred provider. We're obligated only to provide the benefits as specifically stated in the policy.

B. Physician, Hospital or Other Health Care Provider Reports

Physicians, hospitals and other health care providers must give us their records and reports to help us determine benefits due to you. By accepting coverage under the policy you agree to authorize your physicians, hospitals and other health care providers to release all medical records and reports to us for yourself and all your dependents. This is a condition of our providing coverage to you and all your dependents. It's also a continuing condition of our paying benefits. You expressly authorize and direct the following to release these records and reports to us: (1) any physician who has diagnosed for, attended, treated, advised or provided professional services to you; (2) any hospital in which you were treated or diagnosed; and (3) any other health care provider who has diagnosed, attended, treated, advised or provided services to you. You authorize them to furnish to us any and all information related to the health care services or facilities provided to or used by

you, to the extent required by a particular situation and allowed by applicable law. You also expressly authorize us to release to or obtain from any other insurance company or service or benefit plan the information which we need for us to determine our liability to pay benefits under the policy.

C. Other EPIC Coverage

You may have coverage under the policy and other medical coverage under either: (1) a similar EPIC individual or group health insurance policy; or (2) extended benefits payable for you under a prior EPIC individual or group health insurance policy. If so, benefits paid under all EPIC policies combined shall not exceed 100% of the total charges for covered expenses incurred by you while you are insured under those EPIC policies.

D. Assignment of Benefits

This coverage is just for a covered employee and his/her covered dependents. Benefits may be assigned to the extent allowed by the Wisconsin insurance laws.

E. Subrogation

Each member agrees that we shall be subrogated to all of the member's rights to the extent of the benefits we provide under the policy. Those rights are hereby assigned to us to that extent. The assigned rights include, but are not limited to, rights against: (1) all persons or organizations, and their insurers, liable or responsible for paying for losses or damages sustained by the member; (2) automobile liability insurance coverage; (3) underinsured motorists insurance coverage; (4) uninsured motorists insurance coverage; (5) homeowner liability insurance coverage; (6) medical malpractice insurance coverage; (7) patient compensation funds; and (8) any applicable umbrella insurance coverage. The assigned rights shall not be reduced or diminished under any circumstances by attorney's fees, court costs or any other costs of collection which may be incurred by the member.

We have no right to recover from a member if he/she has not been made whole, after taking into consideration his/her comparative negligence. If a dispute arises between us and the member over the question of whether or not the member has been made whole, we have the right to a judicial and jury determination of whether the member has been made whole. Such a determination shall be governed by the rules of evidence, shall require the fact finder to determine the dollar amount that makes the member whole, and in all other substantive and procedural respects shall be conducted as is any other civil jury trial.

Each member shall promptly advise us in writing whenever a claim against any person and/or organization is made on behalf of the member and shall further provide to us such additional information as is reasonably requested by us. The member agrees to fully cooperate in protecting our rights against any person and/or organization. A member shall not enter into a settlement or compromise arrangement with any person and/or organization without our prior written consent. Entering into any such settlement or arrangement is a breach of this contract; such a breach shall be deemed to prejudice our rights.

F. Limitation on Lawsuits and Legal Proceedings

No member shall bring any legal action against us regarding benefits, claims submitted, to compel our payment of benefits or any other matter concerning his/her coverage under the policy until the earlier of: (1) 60 days after we've received or waived proof of claim described in subsection H. Proof of Claim below; or (2) the date we deny payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a member. However, the mere fact that a member has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time we require written proof of claim. Please see subsection H. Proof of Claim below.

G. Severability

Any term, condition or provision of the contract which may be prohibited by Wisconsin law shall be void and be without force or effect. But this won't invalidate the enforceability of any other term, condition or provision of the contract.

H. Proof of Claim

1. Health and Dental.

You, or the physician, hospital or other health care provider on the member's behalf, must submit written proof of his/her claim for each health care service provided to him/her to us within 120 days of the date on which he/she receives that health care service. Written proof of his/her claim includes: (a) the completed claim forms if required by us; (b) the actual itemized bill for each health care service; and (c) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and reports. Circumstances beyond a member's control might prevent him/her from submitting such proof to us within this time period. If so, he/she must file written proof of his/her claim with us as soon as possible; but it can't be later than one year and 120 days after such health care service was provided to him/her, unless the member is legally incapacitated as determined by a court of law during this entire period. If we don't receive the written proof of claim required by us within that one-year and 120-day period and the member is not legally incapacitated, no benefits are payable for that health care service under the policy.

2. Accidental Death and Dismemberment.

- a.** Written proof of your claim includes: (1) the completed claim form required by us; (2) the certified death certificate and autopsy report; and (3) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and other reports. You should request a claim form from the policyholder or from us. This request should be made within 20 days after a loss occurs or as soon as reasonably possible.

When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of claim requirements by giving us a written statement of what happened. We must receive a written statement within the time shown in c. below.

- b.** The claim form must be completed and signed. If a physician must complete part of the claim form, please have the physician complete and sign that portion of the form.
- c.** The completed and signed claim form must be returned to the policyholder who in turn should forward it to us, or you may return the claim form directly to EPIC. The completed and signed claim form must be provided within 90 days after the date of loss, but no later than one year after the date of the loss.

I. Conformity With Laws of the State of Wisconsin

On the effective date of the policy, any term, condition or provision conflicting with the laws of the State of Wisconsin applying to the policy automatically conforms with the minimum requirements of such laws.

J. Entire Contract

The entire contract between you and us is made up of the policy, including the policyholder's group application, the policyholder's supplemental applications, if any, the certificate, Schedule of Benefits, all endorsements, if any, your application, and your supplemental applications, if any.

K. Waiver and Change

Only our Chief Executive Officer can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. At our option, EPIC may unilaterally change any term, condition, exclusion, limitation, or other provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Any change to the policy shall be made by endorsement which is signed by our Chief Executive Officer. Each endorsement shall be binding on the policyholder, each of its members, and EPIC. No error by EPIC, the policyholder, or any member shall invalidate coverage otherwise validly in force, continue or reissue coverage

validly terminated, or cause coverage to be issued which otherwise would not be issued by EPIC. Upon our discovery of any error, an equitable adjustment of coverage, payment of benefits and/or premium shall be made by EPIC at its sole option.

L. Limit on Certain Defenses

After two years have passed from your effective date of coverage under the policy, no misstatement will be used to void your coverage or deny benefits for any claim beginning after the two-year period expires. This doesn't apply to fraudulent misstatements made in your application or any supplemental applications.

M. Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the policy, we have the option of paying benefits either directly to the physician, hospital or other health care provider, or to you as described in subsection N. Claims Processing Procedure below. Payments for covered expenses for which we're liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. If so, we can discharge our liability by paying the organization that has made these payments. In either case, such payments shall fully discharge us from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If we pay more benefits than what we're liable to pay for under the policy, including, but not limited to, benefits paid in error by us, we can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. We can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If we cannot recover such excess benefit payments from any other source, we can also recover such excess benefits payments from you. When we request that you pay us an amount of the excess benefit payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future benefit payments for which we are liable under the policy on other claims by the amount of the excess benefit payments, in order to recover such payments. We will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by us.

N. Claim Processing Procedure

1. Health and Dental.

a. Definitions.

Correctly filed claim: a claim that includes: (1) the completed claim forms if required by us; (2) the actual itemized bill for each health care service; and (3) all other information that we need to determine our liability to pay benefits under the policy, including but not limited to, medical records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, subrogation questionnaire.

Incorrectly filed claim: claim that is filed that lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the policy. Examples would include, but are not limited to, claims filed that are missing procedure codes, diagnosis or dates of service.

b. Procedures.

Benefits payable under the policy will be paid after receipt of a correctly filed claim or utilization review request. EPIC will notify you of its decision on your claim as follows:

- (1) Concurrent Care.** Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must

provide time for you to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a benefit change or termination of the policy.

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

- (2) **Post-Service Claims.** A post-service claim is any claim for a benefit under the policy that is not a pre-service claim within 30 days of receipt of the claim.

If the claim is an incomplete claim or incorrectly filed claim, we may notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

If benefits are payable on charges for services covered under the policy, we'll pay such benefits directly to the hospital, physician or other health care provider providing such services, unless you have already paid the charges and submitted paid receipts therefor to us before we pay benefits. We will send you written notice of the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

If the claim is denied in whole or in part, you will receive a written notice from us with: (1) the specific reason(s) on which denial or partial denial is based; and (2) an explanation of how you may have the claim reviewed by us if you do not agree with our denial or partial denial. Please see subsection O. Grievance Procedures for Health and Dental below.

2. **Accidental Death and Dismemberment.**

Following receipt of a correctly filed claim we will advise the participant or beneficiary of our decision within 90 days of receiving the claim. A correctly filed claim includes: (a) notarized copy of the death certificate; and (b) completed claim form. Under certain circumstances we may need additional information such as accident or injury related - copies of police report, autopsy report, toxicology report, newspaper article(s) or obituary. We determine that the 90-day period begins the date we are in receipt of all completed statement. Any benefits paid under the policy shall fully discharge us from all further liability, to the extent of benefits paid. If benefits are payable under the policy, payment of such benefits shall be made directly to the participant or beneficiary.

In the event of an incomplete claim or circumstances beyond our control, we will advise the participant or beneficiary that a 90-day extension is necessary. An incomplete claim is a correctly filed claim that requires additional information such as additional clinical documentation. In the event an extension is required, we will notify the participant or beneficiary in writing of the reasons for the extension.

If the claim is denied, the participant or beneficiary will receive a written notice from us with: (a) the specific reasons for the denial; (b) the specific references to the policy provisions on which the denial is based; (c) a description of additional material or information which may be necessary for the participant or beneficiary to perfect his/her claim and an explanation of why such material or information is necessary; and (d) an explanation of how the participant or beneficiary may have the claim reviewed by us if he/she does not agree with the denial or partial denial.

O. **Grievance Procedures for Health and Dental**

Situations might occasionally arise when you, as a member, question or are unhappy with a claims decision made by us or some aspect of our policy administration, claims processing, or service that you received from us. For example, you may

question why we made a claims decision or denied benefits for a claim submitted. Since most questions about our payment of benefits, claims processing decision, policy administration, or provision of service can usually be resolved by us without you having to file a grievance under this provision, we urge you first to try to resolve any problem, question, or concern that you have by directly contacting our Member Services Department.

Under this provision you have the right to file a written grievance with us in accordance with your grievance rights under Sections 632.853, and 632.855, Wisconsin Statutes, and Section Ins. 18, Wisconsin Administrative Code, as amended, respectively.

Sections 632.853 and 632.855, Wisconsin Statutes, apply to filing a grievance involving our denial of benefits or coverage for a claim, pre-authorization request, or other request for benefits or coverage submitted to us for a prescription legend drug, durable medical equipment or similar medical device, or an experimental treatment. Only you, as the member, or your authorized representative can use this provision to exercise your right to file a grievance, except as follows. Subject to Section 632.853, Wisconsin Statutes, as amended, your physician may only use this provision to file a grievance on your behalf with respect to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or similar medical device.

The grievance procedure provided under this provision is intended solely to provide you with only the rights available to you, as the member, in accordance with these Wisconsin statutes and this administrative rule, to that extent these laws apply to you. This provision shall be applied and strictly construed by us in accordance with these laws.

But before filing a grievance under this provision, we urge you first to contact our Member Services Department to see if we can resolve this matter to your satisfaction. The first step toward resolving a problem, question, or concern is to bring this matter to our attention by telephoning our Member Services Department. Please see our telephone number shown on your EPIC Identification Card. Our Member Services representative will take your information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. Our representative will then discuss the matter with the Supervisor of our Member Services Department.

If we agree with your proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action that resolves the matter. If, after receiving our response you are still unhappy with our subsequent claims processing action or administrative action that we believe resolves the matter as you proposed, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure explained below.

If our Grievance/Appeal Department upholds our original decision which you questioned or with which you disagreed and if you had contacted us by writing a letter, then we'll automatically forward this matter to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below.

The grievance procedure differs depending upon the type of grievance that is filed with us. Paragraph a. below describes the procedure that we use for handling grievances that are not "expedited grievances" as that term is defined in Section II. of the policy. Paragraph b. below describes the procedure that we use for handling expedited grievances.

For the purpose of paragraph a. and b. below, the terms "you" or "your" and "authorized representative" are defined as follows:

"authorized representative" is a person the member designates to file a grievance on his/her behalf and/or to act for him/her. By designating an authorized representative, this means that for purposes of the grievance the member is also authorizing us to treat that person as if he/she is the member. The member's designation also authorizes us to send that person, not the member, our written decision responding to the grievance. Our committee's written decision will contain personal information about the member, including his/her confidential medical information, if any, that applies to the matter which is being grieved.

"you" or "your" shall mean you, as a member, your authorized representative or your physician (if your physician submitted the grievance that pertains to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or a similar medical device).

a. Grievance Procedure For Grievances That Are Not Expedited Grievances (For Expedited Grievances, please see paragraph b. below).

1. You have three years after you received our initial notice of denial or partial denial of your claim to file a grievance. To file a grievance, you should write down the concerns, issues, and comments and mail, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Department at the address shown below. For example, if we denied benefits for your claim because we determined that a prescription legend drug, a durable medical equipment or medical device, or a treatment provided to you was not “medically necessary” and/or “experimental” as those terms are defined in Section II. of the policy, please send us all additional medical information, including sending us copies of your health care provider(s)’s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under the policy. Any grievance filed by your physician regarding a prescription legend drug or a durable medical equipment or medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that’s not covered under the policy. Please mail, fax, or deliver your written grievance to us at the following address:

Grievance/Appeal Committee
The EPIC Life Insurance Company
C/O Wisconsin Physicians Service Insurance Corporation
P. O. Box 7062
1717 West Broadway
Madison, Wisconsin 53707-7062
Fax Number: (608) 223-3603

We cannot accept telephone requests for a grievance. Your grievance must be in writing. Please deliver, fax, or mail your grievance to us at the address shown above.

2. We will acknowledge our receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of our receipt of the grievance.
3. As soon as reasonably possible following our receipt of the grievance, our Grievance/Appeal Department will review the grievance. Our Grievance/Appeal Department will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy’s applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we’ll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below. Under no circumstances will the time frame exceed the time stated in paragraphs 5. and 6. below.
4. You have a right to appear in person before the Grievance/Appeal Committee which meets at our offices in Madison, Wisconsin, to present written or oral information to the committee and to submit written questions to the person(s) responsible for making the determination which resulted in the grievance. In the committee’s written decision to the grievance the committee will respond to all of the written questions submitted to the committee prior to or at that meeting. The committee will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence that are followed. Also, cross-examination of the committee’s members, its advisors, or EPIC employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the committee. The person’s presentation to the committee may be tape-recorded by the committee. If you attend the meeting to present the reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by the internal practices, rules and requirements established by the committee to handle grievances effectively and efficiently in accordance with the applicable laws.

5. Within 30 days after our receipt of the grievance, the Grievance/Appeal Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the grievance by regular mail using the United States Postal Service unless that person's grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.
6. While reviewing your grievance the committee may need additional time to make its decision. In that case, before the 30-day period mentioned in paragraph 5. above has expired, the committee will send you a written notice by letter that the committee needs an extension of time to complete its review of the grievance and make its decision, how much additional time we need, and when the committee's decision is expected to be made, and the reason additional time is needed. The committee then has an additional 30 days after the first 30-day period has expired (or within 60 days from the date we first received the grievance) to provide you with its written decision. We are precluded by law from delaying our committee's decision beyond that 60-day period even if you request a delay beyond the end of this 60-day period.
7. We will retain our records of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

b. Grievance Procedure For Grievances That Are Expedited Grievances (For Grievances that are not Expedited Grievances, please see paragraph a. above).

1. Please see the definition of the term "expedited grievance" in Section II. Only an expedited grievance that meets that definition's requirements will be handled by us under this provision. If the request isn't an expedited grievance as that term is defined, please use the grievance procedure set forth in paragraph a. above.

To file an expedited grievance, you must call the telephone number shown below to give us the concerns, issues, and comments underlying your grievance, or write down the concerns, issues, and comments and mail, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Department at the address shown below. For example, if we denied benefits for your claim because we determined that a prescription legend drug, a durable medical equipment or medical device, or a treatment provided to you was not "medically necessary" and/or "experimental" as those terms are defined in Section II. of the policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under the policy. Any grievance filed by your physician regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under the policy.

Grievance/Appeal Committee
Expedited Grievance
The EPIC Life Insurance Company
C/O Wisconsin Physicians Service Insurance Corporation
P.O. Box 7062
1717 West Broadway
Madison, Wisconsin 53707-7062
Phone: (608) 226-8054 or toll-free 1-800-765-4977
Fax Number: (608) 223-3603

2. As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Department will review the expedited grievance. Our Grievance/Appeal Department will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action or administrative action that resolves the matter to

your satisfaction. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained below. Under no circumstances will the time frame exceed the time stated in paragraph 3. below.

3. As expeditiously as the participant's health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance/Appeal Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, that has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the expedited grievance by regular mail using the United States Postal Service unless that person's expedited grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.
4. We will retain our records of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

P. Claim Review Procedures for Accidental Death and Dismemberment

If a member or beneficiary does not agree with the denial of his/her claim, we will review our decision in accordance with the following procedure:

1. He/she must file a written appeal and mail it to:

The EPIC Life Insurance Company
Attention: Life & Disability Department
P.O. Box 8430
Madison, Wisconsin 53708-8430

The member or beneficiary must state the specific reasons why he/she does not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, the member or beneficiary may obtain reasonable access to, and copies of, all documents, records and information relevant to his/her claim for benefits.
3. Our review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents and records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review on appeal will be a "fresh" look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of, or the members of which are not subordinates of EPIC's supervisory or managerial employee involved in the denial decision.

If the member's benefit denial was based in whole or in part on a medical judgement, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved with the denial decision, nor be a subordinate of the health care professional who was involved. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon the member's or beneficiary's request, regardless of whether we rely on their advice in making any benefit determinations.

4. Within 60 days after we receive the member's or beneficiary's written request for review, we will send the member or beneficiary a written decision which will contain the specific reasons for our decision and identify the specific policy provisions on which the decision is based.
5. In some situations, we may need additional time to make a decision. In that case, before the 60-day period has expired, we will send the member or beneficiary a written notice that more time is necessary. Then we have up to an additional 60 days after the first 60-day period has expired (a total of 120 days from the date we received the member's or beneficiary's request for review) to provide the member or beneficiary with our decision.