BENEFITS+

(For Annuitants)

SUPPLEMENTAL DENTAL, HOSPITAL INDEMNITY AND ACCIDENTAL DEATH AND DISMEMBERMENT CERTIFICATE

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

Use Of 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 health care provider.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group 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 X. A. of this certificate.

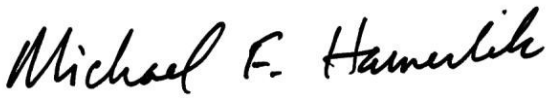
The insurance described in this certificate limits charges for services to the amounts we determine as being reasonable. This amount may be less than the amount billed. Please see the definition of "charge" in Section II. Definitions. If you would like more information, please contact our EPIC Customer 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 an 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



Michael F. Hamerlik, 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 annuitants of the group. We call the group the policyholder. Those persons to whom we have issued certificates are called covered annuitants. Covered annuitants are also called members. If a covered annuitant is issued limited family or family coverage under the group policy, his/her eligible dependents we approved for coverage are also called members. The group policy forms a contract between us and the policyholder. We will 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 X. 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 benefits 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 annuitant 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.

From time to time, the policy may be amended by us. When that happens, a new certificate or endorsement for this certificate will be made available for each covered annuitant. That means your coverage under the policy will change to the extent described in the new certificate or endorsement, as of the effective date of that new certificate or endorsement. This certificate, and all endorsements, if any, should be kept in a safe place for your future reference.

D. Covered Expenses

Benefits are payable only for charges for covered services under the policy. The fact that a health care provider 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 X. 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:

Alcoholism: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 – Alcohol Dependence

Syndrome, 304 – Drug Dependence, 305 – Nondependent Abuse of Drugs, 291- Alcohol-Induced Mental Disorders, or 292 – Drug-Induced Mental Disorders.

Alternate Treatment: if, based on the generally-accepted national standards of medical practice as determined by us, there are other procedures or materials that will provide suitable treatment, covered expenses will be limited to those which are customarily employed and recognized by the medical profession in the United States to be appropriate methods of treatment for the member's illness or injury covered under the policy, taking into account the total current condition of the member who is the patient.

Ambulatory Surgical Center: a licensed facility where the member is admitted to and discharged within the same day with the primary purpose to provide surgical procedures. It has one or more physicians on duty whenever a member is in the center.

An ambulatory surgical center does not include, as determined by us: (a) an office maintained by a physician for the practice of medicine; or (b) a facility which provides services and overnight accommodations for patients.

Annuitant: A WRS Member who has retired and is eligible for group health insurance plans under the WRS, or is the surviving Spouse of an Annuitant. Eligible Annuitants include those who meet at least one of the following criterion:

a. receives a disability annuity under Wis. Stat. §40.63;

b. receives a disability benefit under Long Term Disability Insurance (LTDI) under Subch. Ill of Wis. Admin. Code Ch. 50;

c. receives duty disability benefits under Wis. Stat.§ 40.65;

d. left State service with at least 20 years of creditable service under the WRS, regardless of age; or,

e. has received a retirement lump sum payment.

It does NOT include beneficiaries who were not the Spouse of the Subscriber, nor those who have received a lump sum after separation (vs. retirement.)

A covered employee who becomes an immediate annuitant upon retirement or a surviving spouse of a covered employee shall be allowed to continue under the group plan at group plan ratesincluding any portion paid by the policyholder, providing application is made within 60 days from the date the covered employee becomes an annuitant.

Basic Plan: (a) the State Group Health (SGH) or any other plan or plans, other than this certificate, providing benefits or services to a member arranged through the policyholder and any benefits paid or (b) or any other plan offered by an employer.

Beneficiary: Person or persons who receive the proceeds from the policies Accidental Death benefit.

Board: State of Wisconsin Group Insurance Board that oversees benefits provided under Wisconsin Statutes Chapter 40. Some sources or members may call the Board "G.I.B."

Calendar year: the period of time that starts with your applicable effective date of coverage shown in our records, as determined by us, and ends on December 31st of such year. Each following calendar year shall start on January 1st of that year and end on December 31st of that same year.

Certificate: the document issued by us to a covered annuitant 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 dental 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.

Complaint: Any expression of dissatisfaction expressed to the Insurer by the insured or an insured's authorized representative, about an Insurer or its providers with whom the Insurer has a direct or indirect contract.

Cosmetic Surgery: surgery performed to reshape normal structures of the body in order to improve either the patient's appearance or self-esteem.

Cosmetic Treatment: health care services used to improve either the patient's physical appearance or self-esteem.

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

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

Dental Services: dental treatment, services or supplies provided by one of the following to treat the member's illness or injury: (a) a dentist of a member's choice (other than an immediate family member); (b) a physician of a member's choice and such physician is acting within the lawful scope of practice of a dentist; and (c) a licensed dental professional performing related services requested by a dentist or physician acting within the lawful scope of practice of a dentist.

Dentist: a person who has received a degree in dentistry and is licensed to practice dentistry in the state in which he/she is located and provides dental services while he/she is

acting within the lawful scope of his/her license.

Dependent: a covered annuitant's:

a. Spouse;

b. Child;

c. Legal ward who becomes a legal ward of the covered annuitant, covered annuitant's spouse prior to age 19, but not a temporary ward;

d. Adopted child when placed in the custody of the parent as provided by Wis. Stats. § 632.896;

e. Stepchild;

f. Grandchild if the parent is a dependent child. The dependent grandchild will be covered until the end of the month in which the dependent child turns age 18.

g. A child born outside of marriage becomes a dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Children and Families (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the date of birth if a statement or court order of paternity or a court order is filed within 60 days of the birth.

h. A spouse and a stepchild cease to be dependents at the end of the month in which a marriage is terminated by divorce or annulment.

i. All other children cease to be dependents at the end of the month in which they turn 26 years of age, except that:

(1) An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. EPIC will monitor eligibility annually, notifying the dependent when terminating coverage prospectively upon determining the dependent is no longer so disabled and/or meets the support requirement. EPIC will assist the department in making a final determination if the subscriber disagrees with EPIC's determination.

(2) After attaining age 26, as required by Wis. Stat. § 632.885, a dependent includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

Drug Abuse: a health condition listed in the latest edition of the International Classification of Disease (ICD-9- CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 – Drug Dependence, 305 – Nondependent Abuse of Drugs, 291 – Alcohol-Induced Mental Disorders, or 292 – Drug-Induced Mental Disorders.

Employee: an employee of the policyholder who is eligible for the State sponsored health insurance plans.

Enrollment Period: the period beginning immediately following an eligible annuitant's eligibility date through the 60th day immediately following that eligibility date. For additions to, or changes in, coverage, the enrollment period is stated in Section III. Effective Date.

EPIC: The EPIC Life Insurance Company.

ETF: Department of Employee Trust Funds **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, except for those required by law; 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.

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 a covered annuitant, his/her eligible spouse, his/her eligible dependent children and eligible dependent children of the annuitant's covered spouse. 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.

Full-Time Student: an adult child of a covered annuitant who meets the following criteria:

a. the child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child as attending, on a full-time basis, an institution of higher education; and

b. the child was under the age of 27 when called to federal active duty; and

c. within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age.

The adult child must: (1) attend an accredited school for the number of credits, hours, or

courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a deficit in a member's ability to perform the basic activities of daily living (ADLs), such as dressing, bathing, and eating or the instrumental activities of daily living such as using transportation, shopping or handling finances. The presence of a psychological condition alone will not entitle a member to coverage for plastic or reconstructive surgery.

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 Board 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, physician, dentist, 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: Medical or dental 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.

HIPAA: Health Insurance Portability and Accountability Act, a United States federal law that includes privacy standards to protect personal health information.

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;
(e) sub-acute care center; or (f) a health resort, spa or sanitarium.

Hospital Confinement: the period starting with your admission to a hospital and confinement as an inpatient resident bed patient due to an injury or sickness. The admission must be on the advice of a physician and be medically necessary. If you are

transferred to another hospital for continued treatment of the same or related illness or injury, it is still just one confinement. Confinement ends with your discharge from the hospital. We do not consider confinement to an emergency room, outpatient treatment room or observation unit as hospital confinement.

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. Illness includes pregnancy and complications of pregnancy, alcoholism, drug abuse, or a nervous or mental disorder.

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

Incidental: associated services or items which are integral to the performance of another service or item, or which does not add significant time or effort to the other service or item.

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.

Insurer: Company providing an Insurance plan approved by the Board as an optional, Employee-pay-all benefit.

It's Your Choice: It's Your Choice (IYC), is a designated open enrollment period that is offered to Employees, Annuitants, surviving spouses and dependents who are eligible under the State of Wisconsin Group Health Insurance Program. It is an opportunity to enroll, change plans, change coverage level, or cancel coverage. Changes made become effective January first of the following year. See also Open Enrollment.

Late Enrollee: an eligible annuitant, or dependent of an eligible annuitant, who does not request coverage under the policy during the enrollment period during which the person is entitled to enroll for coverage under the policy and who subsequently requests coverage under the policy. A late enrollee does not include an annuitant or dependent who has voluntarily terminated his/her coverage under the policy.

Leave of Absence: any period in which an Employee is not working for, or receiving earnings from, the Employer and has not terminated the Employer-Employee relationship as defined in Wis. Stat. § 40.02 (40). For the purpose of Optional Insurance, a Leave of Absence ends when the Employee has returned to active work.

Licensed Dental Professional: a person licensed by the state in which he/she resides and provides dental services requested by a dentist or physician while he/she is acting within the lawful scope of his/her license.

Limited Family Coverage: means coverage applies to a covered annuitant and his/her eligible spouse or coverage applies to a covered annuitant and his/her eligible dependent child(ren). 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.

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 service directly provided to you or a hospital confinement or outpatient surgery 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 or dental practice to treat that illness or injury; (c) not solely for your convenience or the convenience of the physician, hospital or other provider; (d) the most appropriate service or location for providing such 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 or dental 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.

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

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

Morbid Obesity/Morbidly Obese: when a member's Body Mass Index (BMI) is 35 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 the International Classification of Disease (ICD-9-CM) within a classification category or codes: 295 - Schizophrenic Disorders; 296 - Episodic Mood Disorders; 297 - Delusional Disorders; 298 - Other Nonorganic Psychoses; 300 - Anxiety, Dissociative and Somatoform Disorders; 301 - Personality Disorders; 302 - Sexual and Gender Identity Disorders; 306 - Physiological Malfunction Arising From Mental Factors; 307 - Special Symptoms or Syndromes, Not Elsewhere Classified; 308 - Acute Reaction to Stress; 309 - Adjustment Reaction; 311 - Depressive Disorder, Not Elsewhere Classified; 312 - Disturbance of Conduct, Not Elsewhere Classified; 313 - Overanxious Disorder; and 314 - Hyperkinetic Syndrome of Childhood.

Optional Insurance Plan: Has the same meaning as Plan.

Open Enrollment: A defined period during which eligible Employees and/or annuitants may enroll, change, or cancel participation in any specific insurance plan. The time frame is

established by the Board, usually for 4 weeks beginning in early to mid-October. For optional insurance, the opportunity to enroll may be further designated by the Insurer, only in agreement with the Board, to limit the employment status or other characteristics that offer eligibility to enroll.

Outpatient Surgery Facility: a facility, licensed as such, that provides surgical services on an outpatient basis. An outpatient surgery facility does not include, as determined by us: (a) a physician's office; (b) a dentist's office;
(c) a clinic; or (d) other similar location.

Physician: a person who has 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 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 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 service which we determine is a covered expense under the policy.

Plan: Insurance plan approved by the Board as an optional, Employee-pay-all benefit, and/or benefit available to Annuitants.

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.

Qualifying Event: Life event that provides an opportunity for a Subscriber to add, cancel, or change coverage. Events can include: marriage, birth or adoption, legal placement of a ward, a dependent child turning age 26, divorce or annulment, leave of absence, death, and loss of comparable coverage. However, not every event listed here allows each type of change. See specific sections for enrollment, change, and cancellation. Source: HIPAA HIPM and Internal Revenue Code.

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

Records: Electronic data or paper files with Subscriber-related information, maintained by the Employer, payroll center, or Insurer.

Services: hospital services, professional services, surgical services, maternity services, medical services, dental 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 annuitant. To be covered, a covered annuitant 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 annuitant's coverage.

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.

Special Enrollment Period: the period of time when a late enrollee is allowed to apply for coverage under the policy, during the State of Wisconsin's It's Your Choice Open Enrollment period. This period of time is determined by the policyholder and approved by us.

Spouse: person in a marriage recognized in the state of Wisconsin.

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.

STAR: "State Transforming Agency Resources." The automated payroll and benefits system for State agencies used by central payroll (most administrative agencies) and the legislature.

State Group Health. or SGH: Group health care benefits for Employees, Annuitants, and their Dependents eligible for coverage offered by the Group Insurance Board as required by Wis.
Stat. § 40.51 and 40.52.

Subscriber: An active Employee or Annuitant who has enrolled in an Optional Insurance plan, who is not enrolled as the Dependent of another Subscriber.

Supplies: medical supplies, dental supplies, durable medical equipment or other supplies directly provided to you by a health care provider, as determined by us.

Surgical Services: an operative procedure performed by a physician and that is recognized by us for the treatment of an illness or injury.

Totally Disabled/Total Disability: a 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 provider for the diagnosis, remedy, therapy, combating, or the combination thereof, of an illness or injury, as determined by us.

UWHC: University of Wisconsin Hospitals and Clinics, an Employer with its own payroll system.

UWS: University of Wisconsin Systems, an Employer with its own payroll system. Does not offer the exact array of Plans as the balance of state agencies.

Ward: An individual for whom a legal guardian has been appointed, under Chapter 54.10 Wis. Stats. Also "legal ward."

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

WEDC: Wisconsin Economic Development Corporation, an Employer with its own payroll system

WHEDA: Wisconsin Housing and Economic Development Authority, an Employer with its own payroll system

WRS: Wisconsin Retirement System.

You, Your: a member

SECTION III. EFFECTIVE DATE

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

A. Annuitant

An eligible annuitant shall become covered under the policy as a member on the first day of the calendar month following the date he/she becomes eligible as an annuitant, provided the annuitant applies within 30 days of his/her eligibility date. If the eligible annuitant applies more than 60 days following his/her eligibility date, such application will be returned and his/her coverage shall not become effective under the policy. That Annuitant will be considered a late enrollee and eligible to apply for coverage as stated in subsection G . Late Enrollees below.

B. Dependents

If an eligible annuitant applies for family coverage or limited family coverage under the policy, each of his/her eligible dependents shall become insured as a member on the latest of: (1) the date the eligible annuitant becomes covered under the policy as a covered annuitant; (2) the date the dependent becomes eligible, provided the eligible annuitant applies within 30 days of his/her dependent's eligibility date (60 days for newborns and adopted children). If the eligible annuitant applies more than 30 days following his/her 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 for coverage as stated in subsection G . Late Enrollees 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.

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 or Limited Family Coverage to Family Coverage Due to Marriage

If a covered annuitant has single coverage or limited family coverage and wishes to change to family coverage to add new eligible dependents because of his/her marriage, he/she must apply using our application form and pay the appropriate premium within 30 days of the date of such marriage. If you properly apply within that 30-day period as required by us, the effective date for family coverage will be the date of marriage. If the covered annuitant applies after that 30-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 for coverage as stated in subsection G . Late Enrollees 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.

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

If a covered annuitant has single coverage or limited family coverage, coverage is provided for his/her 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, the covered annuitant 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 the covered annuitant fails to notify us and pay the required premium to us, coverage for his/her newborn natural child shall terminate at the end of that child's 60-day period, unless the covered annuitant applies for limited family or family coverage using our application form as described below.

If a covered annuitant wishes to change to family coverage to add a newborn natural child, he/she must apply using our application form either: (1) within the first 60 days after the birth of his/her natural child and pay the required premium; or (2) within one year after the birth of his/her natural child and pay all past- due premiums. The effective date for such family coverage will be the date of that child's birth.

If the covered annuitant fails to do either (1) or (2) above, such application will be returned and your newborn natural child will not be covered under the policy. Those dependents will be considered late enrollees and eligible to apply for coverage as stated in subsection G . Late Enrollees below.

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

If a covered employee or annuitant has single coverage or limited family coverage and wishes to change to family coverage to add a new eligible dependent because of his/her adoption of a child or a child placed for adoption, the covered employee or annuitant must apply using an approved 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 the covered employee or annuitant, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. If the covered employee or annuitant properly applies 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 the covered employee's or annuitant's adoption of the child; or (2) on the date that the child is placed for adoption with the covered employee or annuitant, whichever occurs first. If the covered employee or annuitant applies after that 60-day period, the new dependent will be considered a late enrollee and eligible to apply for coverage as stated in subsection G . Late Enrollees below.

If adoption of a child who is placed for adoption with the covered employee or annuitant is not finalized, the child's coverage will terminate when the child's adoptive placement with the covered employee or annuitant 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 a covered annuitant with single, limited family or family coverage to provide coverage for expenses for his/her dependent child, the covered annuitant will be issued limited family or 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 the covered annuitant, the child's other parent, the department of children and families, or the county designee under Section 59.53 (5), 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 the covered annuitant. As long as the covered annuitant is eligible for 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 coverage, as applicable, unless that child's coverage ends sooner in accordance with Section VIII. When Coverage Ends. The covered annuitant 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 he/she becomes aware of that fact.

G. Late Enrollees

A late enrollee may make written application to us only during a special enrollment period determined by the policyholder and approved by us. A late enrollee's effective date of coverage under the policy will be January 1st following the approved special enrollment period.

Those annuitants or dependents who were covered under the policy and voluntarily stop making premium payments, may be denied future enrollment during any approved enrollment period, unless specifically allowed.
A late enrollee must apply using an approved application form and pay the required premium for single, limited family, or family coverage. Benefits are subject to any waiting periods or limitations.

If an eligible annuitant'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 , in some cases temporary coverage may nevertheless be provided to the minimum extent required by Section Ins 6.51 (7m) (b), Wis. Admin. Code, as amended.

H. Transfer of Coverage between Employees

Spouses and subscribers who are both eligible annuitants for this plan may have two single plans or one may carry a limited family or family contract. If one of the members terminates employment the covered annuitants may:

1. combine two single plans into one limited family; or

2. split a limited family contract into two single contracts; or

3. change which spouse is considered to be the covered annuitant under a family contract.

The change in coverage is effective on the first of the month on or after the insurer's receipt of the application.

If an eligible annuitant's or dependent's effective date of regular coverage is deferred under 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 6.51 (7) (b), Wis. Admin. Code, as amended.

J. Additional Changes in Coverage

All Additional changes in overage shall be determined by the policyholder based on the Administration Manual of the State of Wisconsin.

SECTION IV. BENEFIT PROVISIONS

A. Dental Expense Benefit

1. Annual Deductible Amount.

The annual deductible amount is $75.00. The deductible amount applies to each member each calendar year. For each member, charges for covered dental services must add up to the appropriate deductible amount before we pay benefits for other charges for covered dental services. 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 services incurred by that member, subject to the maximum benefit limits shown in paragraph 2. below.

2. Maximum Benefit Limits.

a. The maximum benefit limit for all covered dental services, other than orthodontic services, is: (1) for timely entrants, $1,500 per member per calendar year; and (2) for late enrollees who apply during the special enrollment period, $750 per member for the first calendar year of coverage under the policy, $1,000 per member for the second

calendar year of coverage under the policy, and $1,500 per member per calendar year thereafter.

b. The orthodontic services lifetime maximum benefit limit is $1,200. This lifetime maximum benefit limit applies to the total amount of benefits payable for orthodontic services stated in paragraph 3. n., below, incurred during your lifetime while you are covered under the policy

3. Benefits.

We'll pay benefits at 50% of the charges for the following covered dental services provided during a calendar year by a legally qualified dentist, orthodontist or dental surgeon for the following dental services and supplies. Benefits are not payable for any dental services or supplies payable under your 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 for covered dependents 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 dental services incurred for any one course of orthodontic treatment, including any orthodontic diagnosis, evaluation and pre- orthodontic treatment. Orthodontic treatment must begin before the covered dependent reaches age 19. If orthodontic treatment begins after the covered dependent reaches age 19, benefits for such treatment and services are not payable under the policy and such treatment and services are not covered.

Orthodontic services and supplies are not payable until: (1) if you are a new entrant, you have been covered under the policy for 12 calendar months; or (2) if you are a late enrollee who applied during a special enrollment period, you have been covered under the policy for 24 calendar months.

Consideration of payment for orthodontic 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.

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 dental 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 V. of the policy applies to this subsection. In addition, the following are not 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. Orthodontic treatment that begins after a covered dependent reaches age 19.

d. Dental services that are not medically necessary or not required in accordance with accepted dental practices.

e. Diagnostic and preventive dental services including, but not limited to, dental examinations, regular and periodontal cleaning, fluoride, x-rays, sealants, and emergency evaluations.

f. Orthodontic services and supplies incurred: (1) during the first 12 calendar months following a new entrant's effective date of coverage under the policy; or (2) during the first 24 calendar months following a late enrollee's effective date of coverage under the policy.

g. Dental services not specifically identified paragraph 3. above as being covered under the policy.

h. Dental services furnished by the U.S. Veterans Administration, except for such services for which under applicable federal law the policy is the primary payer and the U.S. Veterans Administration is the secondary payer.

i. Dental services and supplies for cosmetic treatment, 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.

k. Dental services, including oral surgical services, except as specifically stated above.

B. Hospital Indemnity and Outpatient Surgery Indemnity Benefits

1. Hospital Indemnity Benefit.

a. Member Age 65 and Over

We will pay a benefit of $150 for each day of hospital confinement as the result of illness or injury starting on the sixth day of the confinement. The maximum number of days paid per confinement is 360 days.

b. Member Up to Age 65

We will pay a benefit of $200 for each day of hospital confinement as the result of illness or injury starting on the third day of the confinement. The maximum number of days paid per confinement is 363 days.

Once you are discharged from the hospital, additional hospital confinements for the same or different illnesses or injuries will be considered a separate hospital confinement and will be paid according to the policy.

2. Outpatient Surgery Indemnity Benefit.

We will pay a benefit of $200 ($150 for a member age 65 and over) per outpatient surgery performed in an outpatient surgery facility or ambulatory surgical center. Multiple procedures occurring during a single surgical session qualify for a single $200 benefit ($150 for a member age 65 and over).

3. Benefits.

These benefits are not subject to copayments or deductibles. Payments for the benefits will be made directly to the covered annuitant.

4. Exclusions.

The general exclusions stated in Section V. of the policy applies to this subsection. In addition, the following are not covered under the policy:

a. Hospital confinement that does not medically require the patient to be hospitalized or surgery not medically necessary, as determined by us.

b. Routine newborn care. Initial hospital and nursery care, per day, for evaluation and management of normal newborn infant

c. Hospital confinement or surgery services connected with: obesity, weight reduction, or dietetic control care, except for morbid obesity and disease etiology.

d. 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 an illness.

e. Eye refractive surgery.

f. Hospital confinement or surgery services in connection with care for, or leading to, sexual transformation.

g. Reversal of sterilization.

h. Hospital confinement or surgery services in connection with 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 that are incidental to such insemination or fertilization methods.

i. Dental services, including oral surgical services.

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 a covered annuitant, 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 $7,500;

b. with respect to a covered annuitant's 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 $3,750;

c. with respect to a covered annuitant's 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 $1,500;

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 a covered annuitant's life shall be made to the beneficiary as appears on our records, if surviving, otherwise according to the standard sequence established by Wis. Stat. 40.02 (8)(a). Benefits for any other loss shall be paid to the covered annuitant.

A covered annuitant 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 V. apply to the accidental death and dismemberment expense benefits of the policy. In addition, the following are not 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. illness 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. EXCLUSIONS

The following are not covered under the policy. The policy provides no benefits for:

A. Hospital confinement, surgery services, or dental services 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. Hospital confinement, surgery services, or dental 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.

C. Hospital confinement, surgery services, or dental 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.

D. Cosmetic treatment or surgery.

E. War, declared or undeclared.

F. Taking part in a riot, felony or insurrection.

G. Services provided by members of a member's immediate family or anyone else living with him/her.

H. Hospital confinement, surgery services, or dental services for which a proof of claim is not provided to us in accordance with Section X. H. Proof of Claim.

I. 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.

SECTION VI. EXTENSION OF BENEFITS

Termination of coverage will not affect any claim that began while the coverage was in force.

If a member is confined in a hospital on the date coverage terminates we will continue to pay any applicable benefits until the earlier of:

A. The date the member is discharged from the hospital; or

B. 90 days after the date of coverage terminates

SECTION VII. COORDINATION OF BENEFITS (COB)

A. Applicability

1. This section only applies to Section IV. A. Dental when a covered annuitant or the covered annuitant's covered dependent has 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 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.

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 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 dental services.

C. Order of Benefit Determination Rules

1. General.

a. For benefits described in Section IV. A. Dental 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 dental care expenses or if the court decree states that both parents shall be responsible for the dental 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 dental 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. All records remain confidential as provided by state and federal 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 VIII. 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 day immediately following the last day of the calendar month in which you die, (any remaining premium credit balance due to you will be paid to your beneficiary);

C. 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;

D. For a covered annuitant's dependent who is a member, the date the covered annuitant's coverage terminates;

E. For a covered annuitant's spouse who is a memberthe last day of the calendar month the covered annuitant's spouse is no longer married to the covered annuitant due to divorce or annulment.

F. For a dependent child who is a member, the earliest of the following dates:

1. The day immediately following the last day of the calendar month the child reaches age 26;

2. The day immediately following the last day of the calendar month in which the adult child ceases to be a full-time student, if covered under the military provision, as defined in the policy.

3. For step-children, the last day of the calendar month the covered annuitant's spouse is no longer married to the covered annuitant.

G. For a child of a dependent child who is a member, the last day of the calendar month the dependent child reaches age 18;

H. The day immediately following the last day of the calendar month in which a member voluntarily terminates, as determined by your employer, his/her coverage;

I. The last day of the calendar month you enter into military service, other than for duty of less than 30 days, unless you provide copies of your order for active military status and provide applicable premium for coverage under the policy.

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

If a dependent has attained the limiting age while covered under the policy and continues coverage as a full-time student, he/she may continue coverage under the policy provided he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for that full-time student until the earliest of the following dates:

A. He/she advises us that he/she does not intend to return to school full-time;

B. He/she becomes employed full time;

C. He/she obtains other health care coverage;

D. He/she marries and is eligible for coverage under his/her spouse's health coverage;

E. The date coverage of the subscriber through whom he/she has dependent coverage under the policy is discontinued or not renewed; or

F. One year following the date his/her continuation coverage began and he/she has not returned to school on a full-time basis.

SECTION IX. CONTINUATION COVERAGE PRIVILEGE

A. Wisconsin Law

In certain cases you may be eligible to continue your terminated coverage which would otherwise end under Section VIII. When Coverage Ends in accordance with Section 632.897, Wisconsin Statutes, as amended. Those eligible for continuation coverage are: (1) a covered annuitant 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 annuitant'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 annuitant. 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 subject to subsection "C. Premium Reduction Provision". 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 annuitant's spouse, the date the covered annuitant 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 18 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.

Continuation of coverage also allows:

1. An annuitant and his/her dependent(s) may continue coverage indefinitely.

2. A surviving spouse of a deceased annuitant may continue coverage indefinitely.

3. A surviving dependent child of a deceased annuitant may continue coverage until they otherwise lose eligibility.

4. An ex-spouse due to divorce or annulment may continue coverage for up to 36 months, or until the children otherwise lose eligibility.

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

Members must contact the policyholder within 60 days of a divorce or a child losing dependent status under the policy in order to be eligible for COBRA continuation. The member has 60 days following the termination date to elect to continue coverage under COBRA.

If the member is eligible to purchase continuation coverage under COBRA, please see the policyholder for further information.

SECTION X. GENERAL PROVISIONS

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

We will not interfere with the professional relationship you have with your physician, hospital or other provider. We do not 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 are 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 or dental insurance policy; or (2) extended benefits payable for you under a prior EPIC individual or group health or dental 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 annuitant 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. Dental, and Hospital and Outpatient Surgery Indemnity Benefits.

You, or the physician, hospital or other provider on the member's behalf, must submit written proof of his/her claim for each service provided to

him/her to us within 120 days of the date on which he/she receives that service. Written proof of his/her claim includes: (a) the completed claim forms if required by us; (b) the actual itemized bill for each 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 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 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 signed Contract by Authorized Board, 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 EPIC's 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 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. Dental, and Hospital and Outpatient Surgery Indemnity Benefits.

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 dental 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) 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 dental services covered under the policy, we'll pay such benefits directly to the dental provider providing such services, unless you have already paid the charges and submitted paid receipts therefore 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 Dental, and Hospital and Surgery Indemnity Benefits 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 Dental, and Hospital and Outpatient Surgery Indemnity Benefits.

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 Statues, 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 Committee 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 1 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 2. below describes the procedure that we use for handling expedited grievances.

For the purpose of paragraph 1. and 2. 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).

1. Grievance Procedure for Grievances That Are Not Expedited Grievances (For Expedited Grievances, please see paragraph 2. below).

a. 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 Committee at the address shown below. For example, if we denied benefits for your claim because we determined the hospital confinement, surgery services or dental services provided to you

was not "medically necessary" as that term is 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 hospital confinement, surgery services, or dental services was medically necessary 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
P. O. Box 8430
Madison, Wisconsin 53708-8430
Fax Number**:** (608) 223-2159

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.

You have three years after you received our initial notice of denial or partial denial of your claim to file a grievance.

b. 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.

c. As soon as reasonably possible following our receipt of the grievance, our Grievance/Appeal Committee will review the grievance. Our Grievance/Appeal Committee 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 Committee 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 e. and f. below.

d. 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.

e. 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.

f. 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.

g. 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.

2. Grievance Procedure for Grievances That Are Expedited Grievances (For Grievances that are not Expedited Grievances, please see paragraph 1. above).

a. 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 is not an expedited grievance as that term is defined, please use the grievance procedure set forth in paragraph 1. 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 Committee 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
P.O. Box 8430
Madison, Wisconsin 53708-8430
Phone: 1-800-520-5750
Fax Number: (608) 223-2159

b. As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Committee will review the expedited grievance. Our Grievance/Appeal Committee 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 Committee 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 c. below.

c. 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.

d. 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 Committee
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 judgment, 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.

Q. Your Right to Have an Independent Review Organization (IRO) Review Your Dispute

The independent review process provides you with an opportunity to have an independent review organization (IRO) that is approved and certified by the Wisconsin Office of the Commissioner of Insurance (OCI) review your dispute. For a listing of the IRO's, please contact us at the telephone number shown on your Identification Card.

Only disputes that involve medical judgment can be decided through independent review. You can request an independent review if you were denied coverage for a service because we have determined that the service is not medically necessary, experimental or investigative. In addition, the total cost of the denied coverage must exceed $292. The service must be a covered benefit under the policy; benefits specifically excluded from the policy are not eligible for independent review. Pursuant to Wisconsin Statute 632.835(3)(f), as amended, a decision of an IRO is binding on the insured and the insurer, subject to their respective rights under Wisconsin law to appeal that decision to a court of competent jurisdiction.

To request an independent review, you will need to complete our internal grievance procedure, except as specifically stated otherwise in this subsection. You must wait for our determination on your grievance before you can submit your request for independent review. You may send a written request for independent review to the following address:

Wisconsin Physicians Service Insurance
Corporation Attention: IRO Coordinator
P.O. Box 7458
Madison, WI
53708

You must submit your request for an independent review within four consecutive months after receiving notice of the disposition of your grievance and such request must include:

1. Your name, address and telephone number.

2. An explanation of why you believe that the treatment should be covered.

3. Any additional information or documentation that supports your position.

4. If someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative.

5. Any other information requested by us.

You must complete our internal grievance procedure before requesting an independent review. However, you do not need to complete this process if you and us agree to proceed directly to independent review or if you feel that you need immediate medical care. If you need immediate medical treatment and you believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. To do this, send your request to the IRO at the same time you send your request to us. The IRO will review your request and decide if an immediate review is needed. If so, the IRO will review your dispute on an expedited basis. If the IRO determines that your health condition does not require its immediate review of your dispute, it will notify you that you must first complete the internal grievance process provided by us.

After receiving your request for an independent review along with the required information listed in 1. thru 5. above, we will forward all relevant medical records and other documentation used in making our decision to the IRO of your choice within five business days. The IRO then has five business days to review the information and to request any additional information it may need from you or us. After receiving all necessary information, the IRO will make a final, binding determination within 30 business days. If the IRO determines that this time period could jeopardize your life or health, we will send all documents within one day and the IRO will then have two business days to request additional information. The IRO will then make a final, binding decision within 72 hours. All of the information provided by you and us, as the insurer, is reviewed by a clinical peer reviewer.

The IRO and its reviewer are required to consider all of the documentation, including your medical records, your attending provider's recommendation, the terms of the coverage of your health plan, the rationale for our prior decision and any medical or scientific evidence. In addition, some of the information you provide may be shared with the OCI.

The IRO rights described in this subsection are available only to the extent that we're required to provide those rights under Section 632.835, Wisconsin Statutes, as amended, and Chapter Ins 18, Wis. Adm. Code, as amended. Nothing in this subsection provides, or shall be interpreted or construed to provide, any IRO right or rights in excess of, or in addition to, the IRO rights required to be provided by us under Section 632.835, Wisconsin Statutes, as amended, and Chapter Ins 18, Wis. Adm. Code, as amended.

For more information on your IRO rights or to receive an updated copy of Independent Review Organizations available to you, please contact us at the address and telephone number shown on your identification card or visit our website at www.wpsic.com.

You may resolve your problem by taking the steps outlined above. You may also

contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.