

MASTER PLAN DOCUMENT AMENDMENT #3A

Effective April 1, 2006, the Master Plan Document for Midwest Area School Employees' Insurance Trust is hereby amended as follows:

SCHEDULES OF COVERAGE (Amendment #2A, pages 8-14) are hereby deleted and replaced with Attachment A. The Eligible Organ/Tissue Transplant procedure benefit has been updated as follows

1. Added a waiver of the Calendar Year Deductible and Co-payment Percentages (up to \$1,500) during the year in which the transplant occurs, provided the Plan Member participates in the Special Transplant Program.
2. Decreased the maximum benefit payment for transportation, meals, and lodging to \$5,000 per transplant procedure.

DEFINITIONS OF GENERAL TERMS, DEPENDENT (pages 16-18) is hereby deleted and replaced with the following:

DEPENDENT includes only a covered Employee's:

1. Lawful spouse; and
2. Unmarried biological child, adopted child, including a child placed for adoption, a stepchild, and any child for whom the Employee has legal guardianship. Each child must legally constitute a "qualifying child" under Section 152 of the Internal Revenue Code and also be a child:
 - a. Who is less than age 23; or
 - b. Who is otherwise ineligible, but:
 - i) for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law; or
 - ii) who reaches the age limit while covered by this Plan and is incapacitated. The Employee must furnish satisfactory proof to the Plan Administrator that the following conditions continuously exist on and after the date the limiting age is reached. The Plan Administrator may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted

to the Plan Administrator, the child's coverage will not continue beyond the last date of eligibility.

An incapacitated child is one:

1. Who is incapable of self-sustaining employment and is therefore dependent on the Employee for support and maintenance; and
2. Who is unmarried; and
3. Who has a developmental disability and/or physical disability, which is expected to continue indefinitely.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder.

"Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

Placement for adoption occurs when a plan participant or beneficiary, in anticipation of adopting a child assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases.

No person may be covered under this Plan as both an Employee and as a Dependent of an Employee, or as a Dependent of more than one Employee. The term Dependent does not include any person serving in the armed forces of any country.

DEFINITIONS OF GENERAL TERMS, EMERGENCY (page 18) is hereby deleted and replaced with the following:

EMERGENCY means the sudden onset of an Injury or Sickness that, without medical or surgical care, would significantly worsen, become more severe or would result in death. Examples of an Emergency include, but are not limited to: sudden onset of severe chest pain in an adult; severe or sudden shortness of breath; severe or prolonged bleeding from any site; loss of consciousness or sudden change in mental status; seizures; severe or multiple traumatic injuries; severe allergic reaction; severe pain.

COMPREHENSIVE MAJOR MEDICAL BENEFITS, COVERED EXPENSES, Item E6 h (pages 78-79) is hereby deleted and replaced with the following:

h. **Eligible Organ/Tissue Transplant Services** for Eligible Organ/Tissue Transplant Procedures.

Eligible Organ/Tissue Transplant Service means any of the following services, which are Medically Necessary, and rendered to a Plan Member as such services relate to an Eligible Organ/Tissue Transplant Procedure:

- i) Charges for organ/tissue procurement (including typing and acquisition) are payable and **LIMITED** as shown in the Schedule of Coverage.
- ii) Transportation of the Plan Member and a companion to and from the site of the transplant if the Plan Member's home is located 100 or more miles from the site of the transplant. The Plan will cover the cost of regularly scheduled commercial airlines, trains and/or interstate buses. Covered Expenses are payable and **LIMITED** as shown in the Schedule of Coverage. Cab fares, local buses and car rentals are **NOT** Covered Expenses;
- iii) Costs of lodging and meals, for the Plan Member and a companion, are payable and **LIMITED** as shown in the Schedule of Coverage;
- iv) Medical supplies and services, and room and board in a Hospital or in an alternate treatment setting approved by the Plan; and
- v) Drugs and Physician charges.

If a transplant operation is determined to be an Eligible Organ/Tissue Transplant Procedure, Covered Expenses Incurred by a **donor** will be covered as follows:

- i) if the donor is not a Plan Member, but donates to a Plan Member, this Plan will be secondary to any other plan under which the donor is entitled to benefits for these expenses.
- ii) if the donor is covered by this Plan, but the recipient is not, the recipient's plan will be primary for the donor's expenses and this Plan will be secondary. **THE**

RECIPIENT IS NOT ENTITLED TO BENEFITS UNDER THIS PLAN UNLESS HE/SHE IS A COVERED PLAN MEMBER.

- iii) if both the donor and the recipient are covered by this Plan, all Covered Expenses Incurred by both the donor and the recipient will be paid as part of the recipient's claim.

If any organ or tissue is sold rather than donated to a covered recipient, no benefits are payable for the purchase price of such organ or tissue, however, the costs related to the evaluation and procurement are covered for the recipient.

Special Transplant Benefit

In addition to the transplant benefit set forth above, a Special Transplant Benefit may be available when a Plan Member participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the program is voluntary. Additional information regarding the Special Transplant Program may be obtained from the Plan Administrator.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

- i) Access to Centers of Excellence Transplant Facilities throughout the United States;
- ii) Waiver of the Calendar Year Deductible and Co-payment Percentages up to \$1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Plan Member participates in the Special Transplant Program and satisfies all of the following requirements:

- i) Notification of the transplant procedure must be provided to EBC-Review in accordance with the Notification of Inpatient Hospital Admission Provision;
- ii) In addition, the Plan Member must call EBC-Review and the Special Transplant Program at 1-888-4ORGANS as soon as the Plan Member is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
- iii) All transplant services must be rendered at a Centers

of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from the Plan Administrator.

Accepted By:

Name:	Title	Date
For:	Midwest Area School Employees' Insurance Trust	

**SCHEDULE OF COVERAGE
PLAN 1**

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER CALENDAR YEAR

PPO:	\$750	INDIVIDUAL	NON-PPO:	\$3,000	INDIVIDUAL
	\$1,500	FAMILY		\$6,000	FAMILY

The PPO Deductible and the Non-PPO Deductible are separate Deductibles and will **NOT** be used to satisfy each other.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR

PPO:	\$1,650	INDIVIDUAL	NON-PPO:	\$5,900	INDIVIDUAL
	\$3,300	FAMILY		\$11,800	FAMILY

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum are separate maximums and will **NOT** be used to satisfy each other. The Out-of-Pocket Maximum does **NOT** include Copays and charges payable by the Plan Member (other than the Deductible) for Outpatient treatment of Mental/Nervous Disorders and/or Substance Abuse.

LIFETIME MAXIMUM PAYMENT AMOUNT

Inpatient and Outpatient treatment of Substance Abuse	\$25,000
All benefits combined	\$2,000,000

NOTIFICATION OF INPATIENT HOSPITALIZATION IS REQUIRED WITHIN 48 HOURS AFTER ADMISSION. NON-COMPLIANCE REDUCES BENEFITS. TELEPHONE: EBC-REVIEW, IN THE MILWAUKEE AREA AT (414) 365-4630; OUTSIDE OF THE MILWAUKEE AREA AT 1-800-426-9317. IF A PLAN MEMBER DOES NOT COMPLY WITH THE NOTIFICATION OF INPATIENT HOSPITALIZATION WHEN REQUIRED, COVERED EXPENSES WILL BE REDUCED BY \$700 PER CONFINEMENT (THIS REDUCTION IS IN ADDITION TO THE CALENDAR YEAR DEDUCTIBLE). IF THERE IS A REDUCTION IN BENEFITS DUE TO NON-COMPLIANCE WITH THE NOTIFICATION OF INPATIENT HOSPITALIZATION PROGRAM, THE PENALTY THAT THE PLAN MEMBER HAS TO PAY WILL NOT BE APPLIED TO THE OUT-OF-POCKET MAXIMUM.

Attachment A – Effective April 1, 2006

Benefit Description	Copay PPO/ Non-PPO	Deductible PPO/ Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Pre-admission Testing	No/No	No/Yes	100%	60%	PPO charges must be Incurred within 7 days prior to the admission.
Hospital Emergency Room Services (Emergency Sickness and Injury)	No/No	Yes/Yes	80%	80%	Treatment of a non-emergency Sickness is NOT covered.
Inpatient treatment of Mental/Nervous Disorders	No/No	Yes/Yes	80%	60%	Inpatient care is LIMITED to a maximum of 30 days per Calendar Year. Two days of day hospitalization (transitional care) are equivalent to one day of Inpatient care and will reduce the number of covered Inpatient care days accordingly.
Outpatient treatment of Mental/Nervous Disorders	No/No	Yes/Yes	80%	60%	Outpatient care is LIMITED to a maximum of 30 visits per Calendar Year.
Inpatient treatment of Substance Abuse	No/No	Yes/Yes	80%	60%	Covered Expenses are subject to the Lifetime Maximum Payment Amount for Inpatient and Outpatient treatment of Substance Abuse.
Outpatient treatment of Substance Abuse	No/No	Yes/Yes	80%	60%	Outpatient care is LIMITED to a maximum benefit payment of \$50 per visit up to a maximum benefit payment of \$1,500 per Calendar Year and subject to the Lifetime Maximum Payment Amount for Inpatient and Outpatient treatment of Substance Abuse.
Physician Office Visits/Services (other than for Mental/Nervous Disorders and/or Substance Abuse and Chiropractic Care)	\$20 per visit/\$20 per visit	Yes/Yes	80%	60%	Only one office visit Copay will apply for all services rendered in the Physician's office on the same day, regardless if an office visit is billed.
Chiropractic Care	No/No	Yes/Subject to the PPO Deductible	80%	80%	
Routine Well Child Exams	No/No	No/No	80%	60%	LIMITED to a maximum of 3 visits and to children under 12 months of age.
Routine immunizations	No/No	No/No	100%	100%	LIMITED to children 12 months of age or older but less than 23 years of age.

Attachment A – Effective April 1, 2006

Benefit Description	Copay PPO/ Non-PPO	Deductible PPO/ Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Routine Exams for Employees and their spouses	No/No	The first \$300 of Covered Expenses per 24-month period are not subject to the Deductible. Charges in excess of \$300 during this period (PPO and/or Non-PPO) are subject to the Deductible.	80%	60%	Pap smears are LIMITED to one per Calendar Year; Mammograms are LIMITED to one per Calendar Year; Prostate specific antigen tests are LIMITED to one per Calendar Year; Colon/Rectal exams are LIMITED as described under the benefits section of the Plan.
Eligible Organ/Tissue Transplant Services	No/No	Yes/Yes	100%	100%	Donor procurement expenses related to a covered transplant procedure LIMITED to a maximum benefit payment of \$10,000 per transplant procedure. Transportation, meals & lodging related to a covered transplant procedure LIMITED to a maximum benefit payment of \$5,000 per transplant procedure. For Plan Members participating in the Special Transplant Program, the Deductible is waived and benefits are payable at 100% up to a maximum of \$1,500 during the year in which the transplant occurs. Charges in excess of \$1,500 are subject to the Deductible and standard Payment Percentages.
Hospice counseling	No/No	Yes/Yes	80%	60%	Covered Expenses are LIMITED to a Lifetime maximum of \$7,500
Home Health Care	No/No	Yes/Yes	80%	60%	
Ambulance services	No/No	Yes/Subject to the PPO Deductible	80%	80%	
Diagnostic testing relating to infertility	No/No	Yes/Yes	80%	60%	Once a diagnosis of infertility has been made, no additional benefits are payable.
All other Covered Expenses	No/No	Yes/Yes	80%	60%	

THE PPO IS ADMINISTERED BY:

**SAGAMORE HEALTH NETWORK,
ENCORE HEALTH NETWORK or
COMMUNITY HEALTH ALLIANCE (CHA)**

Attachment A – Effective April 1, 2006

RESTAT/IPS PRESCRIPTION DRUG CARD BENEFIT

COPAY PER PRESCRIPTION/REFILL

RETAIL PURCHASES	
GENERIC DRUGS	\$10/Rx or 20%, whichever is greater
BRAND NAME DRUGS	\$25/Rx or 20%, whichever is greater

MAIL ORDER PURCHASES	
GENERIC DRUGS	\$20/Rx or 20%, whichever is greater
BRAND NAME DRUGS	\$50/Rx or 20%, whichever is greater

SUPPLY LIMIT PER PRESCRIPTION/REFILL

RETAIL PURCHASES	30 DAYS
MAIL ORDER PURCHASES	90 DAYS

**SCHEDULE OF COVERAGE
PLAN 2**

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER CALENDAR YEAR

PPO:	\$1,050 INDIVIDUAL	NON-PPO:	\$3,100 INDIVIDUAL
	\$2,100 FAMILY		\$6,200 FAMILY

The PPO Deductible and the Non-PPO Deductible are separate Deductibles and will **NOT** be used to satisfy each other.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR

PPO:	\$5,000 INDIVIDUAL	NON-PPO:	\$11,000 INDIVIDUAL
	\$10,000 FAMILY		\$22,000 FAMILY

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum are separate maximums and will **NOT** be used to satisfy each other. The Out-of-Pocket Maximum does **NOT** include charges payable by the Plan Member (other than the Deductible) for Outpatient treatment of Mental/Nervous Disorders and/or Substance Abuse.

LIFETIME MAXIMUM PAYMENT AMOUNT

Inpatient and Outpatient treatment of Substance Abuse	\$25,000
All benefits combined	\$2,000,000

NOTIFICATION OF INPATIENT HOSPITALIZATION IS REQUIRED WITHIN 48 HOURS AFTER ADMISSION. NON-COMPLIANCE REDUCES BENEFITS. TELEPHONE: EBC-REVIEW, IN THE MILWAUKEE AREA AT (414) 365-4630; OUTSIDE OF THE MILWAUKEE AREA AT 1-800-426-9317. IF A PLAN MEMBER DOES NOT COMPLY WITH THE NOTIFICATION OF INPATIENT HOSPITALIZATION WHEN REQUIRED, COVERED EXPENSES WILL BE REDUCED BY \$700 PER CONFINEMENT (THIS REDUCTION IS IN ADDITION TO THE CALENDAR YEAR DEDUCTIBLE). IF THERE IS A REDUCTION IN BENEFITS DUE TO NON-COMPLIANCE WITH THE NOTIFICATION OF INPATIENT HOSPITALIZATION PROGRAM, THE PENALTY THAT THE PLAN MEMBER HAS TO PAY WILL NOT BE APPLIED TO THE OUT-OF-POCKET MAXIMUM.

Benefit Description	Deductible PPO/Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Pre-admission Testing	Yes/Yes	80%	60%	PPO charges must be Incurred within 7 days prior to the admission.
Surgery performed in a Physician's office	Yes/Yes	80%	60%	
Hospital Emergency Room Services (Emergency Sickness and Injury)	Yes/Yes	80%	80%	Treatment of a non-emergency Sickness is NOT covered.

Attachment A – Effective April 1, 2006

Benefit Description	Deductible PPO/Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Inpatient treatment of Mental/Nervous Disorders	Yes/Yes	80%	60%	Inpatient care is LIMITED to a maximum of 30 days per Calendar Year. Two days of day hospitalization (transitional care) are equivalent to one day of Inpatient care and will reduce the number of covered Inpatient care days accordingly.
Outpatient treatment of Mental/Nervous Disorders	Yes/Yes	80%	60%	Outpatient care is LIMITED to a maximum of 30 visits per Calendar Year.
Inpatient treatment of Substance Abuse	Yes/Yes	80%	60%	Covered Expenses are subject to the Lifetime Maximum Payment Amount for Inpatient and Outpatient treatment of Substance Abuse.
Outpatient treatment of Substance Abuse	Yes/Yes	80%	60%	Outpatient care is LIMITED to a maximum benefit payment of \$50 per visit up to a maximum benefit payment of \$1,500 per Calendar Year and subject to the Lifetime Maximum Payment Amount for Inpatient and Outpatient treatment of Substance Abuse.
Chiropractic Care	Yes/Yes	80%	80%	
Routine Well Child Exams	No/No	80%	60%	LIMITED to a maximum of 3 visits and to children under 12 months of age.
Routine immunizations	No/No	100%	100%	LIMITED to children 12 months of age or older but less than 23 years of age.
Routine Exams for Employees and their spouses	The first \$300 of Covered Expenses per 24-month period are not subject to the Deductible. Charges in excess of \$300 during this period (PPO and/or Non-PPO) are subject to the Deductible.	80%	60%	Pap smears are LIMITED to one per Calendar Year; Mammograms are LIMITED to one per Calendar Year; Prostate specific antigen tests are LIMITED to one per Calendar Year; Colon/Rectal exams are LIMITED as described under the benefits section of the Plan.

Attachment A – Effective April 1, 2006

Benefit Description	Deductible PPO/Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Eligible Organ/Tissue Transplant procedures	Yes/Yes	80%	80%	<p>Donor procurement expenses related to a covered transplant procedure LIMITED to a maximum benefit payment of \$10,000 per transplant procedure.</p> <p>Transportation, meals & lodging related to a covered transplant procedure LIMITED to a maximum benefit payment of \$5,000 per transplant procedure.</p> <p>For Plan Members participating in the Special Transplant Program, the Deductible is waived and benefits are payable at 100% up to a maximum of \$1,500 during the year in which the transplant occurs. Charges in excess of \$1,500 are subject to the Deductible and standard Payment Percentages.</p>
Hospice counseling	Yes/Yes	80%	60%	Covered Expenses are LIMITED to a Lifetime maximum of \$7,500
Home Health Care	Yes/Yes	80%	60%	
Ambulance services	Yes/Yes	80%	80%	
Diagnostic testing relating to infertility	Yes/Yes	80%	60%	Once a diagnosis of infertility has been made, no additional benefits are payable.
Prescription Drug	Yes/Subject to the PPO Deductible	80%	80%	Includes oral contraceptives.
All other Covered Expenses	Yes/Yes	80%	60%	

THE PPO IS ADMINISTERED BY: **SAGAMORE HEALTH NETWORK,
ENCORE HEALTH NETWORK or
COMMUNITY HEALTH ALLIANCE (CHA)
BEECHSTREET**