

MASTER PLAN DOCUMENT AMENDMENT #5A

Effective January 1, 2007, the Master Plan Document for Midwest Area School Employees' Insurance Trust is hereby amended as follows:

SCHEDULES OF COVERAGE (Amendment #3A, pages 6-12) are hereby deleted and replaced with Attachment A. For Plan 2 the Deductible per Calendar Year will increase to: PPO - \$1,200 for Single Coverage and \$2,400 for Family Coverage; and Non-PPO - \$3,600 for Single Coverage and \$7,200 for Family Coverage.

SPECIAL DEDUCTIBLE PROVISIONS (pages 87-88) is hereby deleted and replaced with the following:

SPECIAL DEDUCTIBLE PROVISIONS

The Deductible amount can only be satisfied by Covered Expenses. The Deductible applies to all Covered Expenses **UNLESS** specifically stated otherwise.

Under Plan 1 only, if two or more members of a covered family are injured in the same accident, only one Deductible amount will be subtracted from all Covered Expenses related to that accident.

Once a family has collectively satisfied the family Deductible amount as shown in the Schedule of Coverage during a Calendar Year, no further Deductibles will be applied to Covered Expenses for other members of the family for the remainder of the Calendar Year. **NOTE:** Under Plan 1 only, no individual will ever pay more than an individual Deductible.

Under Plan 2, the Deductible for Family Coverage must be satisfied in full each Calendar Year, by one or more covered family members, before benefits are payable by the Plan.

Under Plan 1 only, Covered Expenses Incurred during October, November or December, which are used to satisfy all or part of the individual and family Deductibles will also be used to satisfy the individual and family Deductibles for the next Calendar Year. Any Deductible carryover will be based on the date a Covered Expense is Incurred.

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

SPECIAL OUT-OF-POCKET MAXIMUM BENEFIT (page 88) is hereby deleted and

replaced with the following:

SPECIAL OUT-OF-POCKET MAXIMUM BENEFIT FOR PLAN 1 ONLY

The Out-of-Pocket maximum is the total amount of Covered Expenses that are payable by the Plan Member during a Calendar Year. It is comprised of the Deductible amount and Co-payment Percentage not covered by the Plan. The Out-of-Pocket maximum is shown in the Schedule of Coverage.

The PPO Out-of-Pocket maximum will **NOT** be used to satisfy the Non-PPO Out-of-Pocket maximum.

The Out-of-Pocket maximum does **NOT** include:

1. Charges Incurred for services and supplies which are not covered by the Plan.
2. Copays.
3. Charges Incurred in excess of any maximum benefit listed in the Plan.
4. Co-payment Percentage payable by the Plan Member for the Outpatient treatment of Mental/Nervous Disorders and/or Substance Abuse.
5. Any penalty payable by the Plan Member for non-compliance with the Notification of Inpatient Hospitalization provision

SPECIAL OUT-OF-POCKET MAXIMUM BENEFIT FOR PLAN 2 ONLY

The Out-of-Pocket maximum is the total amount of Covered Expenses that are payable by the Plan Member during a Calendar Year. It is comprised of the Deductible amount and Co-payment Percentage not covered by the Plan. The Out-of-Pocket maximum is shown in the Schedule of Coverage.

The PPO Out-of-Pocket maximum will **NOT** be used to satisfy the Non-PPO Out-of-Pocket maximum.

The Out-of-Pocket maximum does **NOT** include:

1. Charges Incurred for services and supplies which are not covered by the Plan.

2. Charges Incurred in excess of any maximum benefit listed in the Plan.
3. Any penalty payable by the Plan Member for non-compliance with the Notification of Inpatient Hospitalization provision

PRESCRIPTION DRUG CARD PROGRAM (page 89) is hereby deleted and replaced with the following:

**PRESCRIPTION DRUG CARD PROGRAM
PLAN 1 ONLY**

For additional information, please refer to the material provided by the Prescription Drug Card administrator or contact them at the phone number listed on the Prescription drug card. The Prescription Drug Card administrator will be able to assist the Plan Member in determining the benefits, limitations and exclusions relative to the Prescription Drug Card Program, which may differ from the benefit, limitations and exclusion in this Plan.

NOTE: This provision does **NOT** apply to Plan 2.

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 January 1, 2007

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 January 1, 2007

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 January 1, 2007

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:	\$1,200 SINGLE COVERAGE	NON-PPO:	\$3,600 SINGLE COVERAGE
	\$2,400 FAMILY COVERAGE		\$7,200 FAMILY COVERAGE

NOTE: If a Plan Member is covered for Family Coverage, the Calendar Year Family Coverage Deductible must be satisfied in full (by one or more family members) before benefits are payable by the Plan.

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:	NON-PPO:
\$5,000 INDIVIDUAL	\$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%	

Attachment A – Effective January 1, 2007

Benefit Description	Deductible PPO/Non-PPO	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Hospital Emergency Room Services (Emergency Sickness and Injury)	Yes/Yes	80%	80%	Treatment of a non-emergency Sickness is NOT covered.
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.

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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**