

Uniform Benefits Certificate of Coverage

THIS IS YOUR DESCRIPTION OF BENEFITS FOR HMOs, SMP AND WPS METRO CHOICE'S PPP (ALTERNATE PLANS)

The Group Insurance Board adopted a uniform medical insurance benefits package for alternate health plans. This affects State of Wisconsin employees and annuitants, and local government employees whose employers participate in the Department of Employee Trust Funds (ETF) health insurance programs.

The purpose of Uniform Benefits is to help contain the rising cost of health insurance and simplify the selection of a health plan for employees. Employees and annuitants are able to decide on which plan to select on the basis of:

1. Cost of the plan to them
2. Quality of services provided
3. Access to specific physicians or other health care providers
4. Plan referral policies

Uniform Benefits does not mean that all plans will treat all illnesses in an identical manner. Treatment will vary depending on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan. See Section G for health plan specific information

The following pages describe the benefits which will be offered by all alternate plans in 2009. Your plan is not required to provide a separate description of benefits. **It is very important that you keep this brochure for your reference throughout 2009.** If you have questions, please contact the plans directly.

The Uniform Benefits will cover some oral surgery, but alternate plans also have the option of offering other dental benefits. **Plans offering dental benefits are listed in Section G starting on page G-2.**

Uniform Benefits do not apply to the Standard Plan except that their prescription drug coverage is through the Pharmacy Benefit Manager (PBM).

NOTABLE CHANGE TO UNIFORM BENEFITS
EFFECTIVE JANUARY 1, 2009

<i>Topic</i>	<i>Page</i>	<i>Section</i>	<i>Year 2009 Benefit</i>	<i>Year 2008 Benefit</i>
Annual Prescription Drug Out-of-Pocket Maximum	D-7	Schedule of Benefits	For all participants, except those enrolled in the Standard Plan: \$385 per individual \$770 per family For participants enrolled in the Standard Plan: \$1,000 per individual \$2,000 per family	For all participants, except those enrolled in the Standard Plan: \$350 per individual \$700 per family For participants enrolled in the Standard Plan: \$1,000 per individual \$2,000 per family

The benefit change described above is a notable change to Uniform Benefits for 2009. Other minor modifications have been made to clarify the intent of specific contract language, however, these clarifications do not change your level of coverage.

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I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at \$0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits. This also does not include Your lifetime maximum benefit if You were previously covered by the Health Plan, as Your lifetime maximum benefit may include any benefits paid during all periods of coverage with the same Health Plan under this program.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin group health insurance program.

NOTE: For Participants enrolled in a Preferred Provider Plan (WPS Metro Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.

The benefits that are administered by the Health Plan are subject to the following:

- Policy Deductible: NONE
- Policy Coinsurance: 100% of charges, except as described below
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: \$2,000,000 per Participant
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per calendar year.
- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed \$500.00 annually per Participant.

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- One hearing aid per ear no more than once every three years payable at 80%, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Cochlear Implants: Device, surgery for implantation of the device, and follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, payable at 80%. Hospital charges for the surgery are covered at 100%. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. Fifty additional Medically Necessary visits per calendar year may be authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is 6 months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of \$1,000,000 for transplants, including Preoperative and Postoperative Care.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services:

Outpatient Services: \$1,800 maximum per Participant per calendar year
Transitional Services: \$2,700 maximum per Participant per calendar year
Inpatient Services: 30 days or \$6,300, whichever is less, per Participant per calendar year

Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per Participant per calendar year.

The maximum is determined using the average amount paid to the Providers by the Health Plan and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to Copayment.

Note: Annual dollar maximums for mental health only services are suspended. However, day limit maximums do apply, if applicable.

Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.

- Vision Services: One routine exam per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)
- Oral Surgery: Limited to procedures listed in Benefits and Services Section.
- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.
- Hospital Emergency Room Copayment: \$60 per visit; waived if admitted as an inpatient directly from the emergency room. (An inpatient stay is generally 24 hours or longer.)

The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

- Prescription Drugs and Insulin:

Level 1* Copayment for Formulary Prescription Drugs:	\$ 5.00
Level 2**Copayment for Formulary Prescription Drugs:	\$15.00
Level 3 Copayment for Covered Non-Formulary Prescription Drugs:	\$35.00

*Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.

**Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.

Annual Out-of-Pocket Maximum (The amount You pay for Your Level 1 and Level 2 Prescription Drugs and Insulin):

\$385 per individual or \$770 per family for all Participants, except:

\$1,000 per individual or \$2,000 per family for Participants enrolled in the Standard Plan

NOTE: Level 3 Copayments do not apply to the out-of-pocket maximum and must continue to be paid after the annual out-of-pocket maximum has been met.

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.
- Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

II. DEFINITIONS

The terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this plan.

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.
- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.
- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a Plan Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the medical or surgical treatment will enable that person to live outside an institution.

Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEPENDENT:** Means the Subscriber's:
 - ▶ Spouse.
 - ▶ Unmarried child.
 - ▶ Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward.
 - ▶ Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
 - ▶ Stepchild.
 - ▶ 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.

A Dependent child must be 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.

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 Health and Family Services or equivalent if the birth was outside of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

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. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. A child age 19 or over who is a full-time student, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be a Dependent:
 - ▶ At the end of the calendar year in which the child ceases to be a full-time student or in which the child turns age 25, whichever occurs first.
 - ▶ At the end of the month in which the child marries.

Student status includes any intervening vacation period if the child continues to be a full-time student. As defined in Wis. Adm. Code § ETF 10.01 (5), student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the Dependent ceases to be a full-time student due to a medically necessary leave of absence.

2. A 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, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a Dependent for federal income tax purposes and is not married). The Health Plan will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the Dependent is no longer

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so disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
 4. Any Dependent eligible for benefits will be provided benefits based on the date of eligibility, not on the date of notification to the Health Plan and/or PBM.
- **DURABLE MEDICAL EQUIPMENT:** Means an item which can withstand repeated use and is, as determined by the Health Plan, primarily used to serve a medical purpose with respect to an Illness or Injury, generally not useful to a person in the absence of an Illness or Injury, appropriate for use in the Participant's home, and prescribed by a Plan Provider.
 - **EFFECTIVE DATE:** The date, as certified by the Department of Employee Trust Funds and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
 - **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
 - **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:
 1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
 2. Serious impairment to the Participant's bodily functions.
 3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in Section III., A., 1., e. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.
- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly

performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies.
- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this calendar year.
- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.
- **HOSPITAL:** Means an institution that:
 1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
 2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.

- **HOSPITAL CONFINEMENT or CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or

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Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses.
- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.
- **MAINTENANCE THERAPY:** Means ongoing therapy delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a Provider.
- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; (2) appropriate under the standards of acceptable medical practice to treat that Illness or Injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care Provider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MEDICAID:** Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
- **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.

- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.
- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Health Plan unless it is an Emergency or Urgent Care.
- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:
 1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
 2. Re-assessment and intervention (individual and group)
 3. Diabetes outpatient self-management training services (individual and group sessions)
 4. Dietitian visit
- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
- **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.

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- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.
- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.
- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital or elsewhere necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.
- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

You must name Your Primary Care Provider on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
- **PROVIDER:** Means a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does

not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.

- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.
- **SKILLED NURSING FACILITY:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.
- **SPECIALTY MEDICATIONS:** Means medications that require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals to Non-Plan Providers are not subject to Usual and Customary Charges. However, Emergency or

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urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

The benefits and services which the Health Plan and PBM agrees to provide to Participants, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the Participant's Primary Care Provider (except in the case of plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a plan Hospital. In the case of non-Emergency care, the Health Plan reserves the right to determine in a reasonable manner the Provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the Health Plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for Emergency and Urgent Care, You must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan Provider or You will be financially responsible for the services. The Health Plan may also require Prior Authorization for other services or they will not be covered.

Subject to the terms and conditions outlined in this plan and the attached Schedule of Benefits, a Participant, in consideration of the employer's payment of the applicable Health Plan and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any Copayment, Coinsurance and other limitations shown in the Schedule of Benefits; and (b) all other terms and conditions outlined in this plan. All services must be Medically Necessary, as determined by the Health Plan and/or PBM.

A. Medical/Surgical Services

1. Emergency Care

- a. Medical care for an Emergency, as defined in Section II. Refer to the Schedule of Benefits for information on the emergency room Copayment.
- b. Plan Hospital emergency rooms should be used whenever possible. Should You be unable to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You are receiving Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan. In addition to the emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.
- c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility

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Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

- d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.
- e. Some examples of Emergencies are:
 - ▶ Acute allergic reactions
 - ▶ Acute asthmatic attacks
 - ▶ Convulsions
 - ▶ Epileptic seizures
 - ▶ Acute hemorrhage
 - ▶ Acute appendicitis
 - ▶ Coma
 - ▶ Heart attack
 - ▶ Attempted suicide
 - ▶ Suffocation
 - ▶ Stroke
 - ▶ Drug overdoses
 - ▶ Loss of consciousness
 - ▶ Any condition for which You are admitted to the Hospital as an inpatient from the emergency room

2. Urgent Care

- a. Medical care received in an Urgent Care situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan.
- c. Some examples of Urgent Care cases are:
 - ▶ Most Broken Bones
 - ▶ Minor Cuts
 - ▶ Sprains
 - ▶ Most Drug Reactions
 - ▶ Non-Severe Bleeding
 - ▶ Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for an Illness or Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants.

4. Reproductive Services

The following services do not require a Referral to a Plan Provider who specializes in obstetrics and gynecology, however, the Health Plan may require that the Participant obtain Prior Authorization for some services or they may not be covered.

- a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, Cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of birth). In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is Medically Necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.
- b. Elective sterilization.
- c. Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
- d. IUDs , as described under the Durable Medical Equipment provision.
- e. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the Participant is in her second or third trimester of pregnancy when the Provider's participation in the Health Plan terminates, the Participant will continue to have access to the Provider until completion of postpartum care for the woman and infant. A Prior Authorization is not required for the delivery, but the Health Plan may request that it be notified of the inpatient stay prior to the delivery or shortly thereafter.

5. Medical Services

Medically Necessary professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an approved Provider.

- a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.
- c. Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
- d. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)
- e. Injectable and infusible medications, except for Self-Administered Injectable medications.

- f. Nutritional Counseling provided by a participating registered dietician or Plan Provider.
- g. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

6. Anesthesia Services

Covered when provided in connection with other medical and surgical services covered under this plan. It will also include anesthesia services for dental care as provided under item B., 1., c. of this section.

7. Radiation Therapy

Covered when accepted therapeutic methods, such as x-rays, radium and radioactive isotopes are administered and billed by an approved Provider.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route, as described in the Schedule of Benefits. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, x-rays and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

11. Outpatient Physical, Speech and Occupation Therapy

Medically Necessary services as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit maximum described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.

12. Home Care Benefits

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

All home care must be Medically Necessary as part of the home care plan. Home care means one or more of the following:

- a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
- b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
- c. Physical, occupational and speech therapy. (These apply to the therapy maximum.)
- d. Medical supplies, drugs and medicines prescribed by a Health Plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Confined in a Hospital.
- e. Nutritional Counseling. A registered dietician must give or supervise these services.
- f. The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

- 1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.
- 2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.
- 3) A state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A Participant may have been Confined in a Hospital just before home care started. If so, the home care plan must be approved, at its start, by the physician who was the primary Provider of care during the Hospital Confinement.

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per calendar year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating Your needs or developing a plan counts as one visit. Each period of four (4) straight hours in a twenty-four (24) hour period of home health aide services counts as one home care visit.

13. Hospice Care

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice Care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for 1 year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Health Plan.

14. Phase II Cardiac Rehabilitation

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

15. Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury

Total extraction or total replacement (limited to, bridge or denture) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within eighteen months of the accident. Crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the Health Plan before the service is performed. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision.

16. Oral Surgery

Participants should contact the Health Plan prior to any oral surgery to determine if Prior Authorization by the Health Plan is required. When performed by Plan Providers, approved surgical procedures are as follows:

- a. Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.
- b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
- c. Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)
- d. Surgical procedures required to correct accidental Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such Injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.
- e. Apicoectomy. (Excision of apex of tooth root.)
- f. Excision of exostoses of the jaws and hard palate.
- g. Intraoral and extraoral incision and drainage of cellulitis.
- h. Incision of accessory sinuses, salivary glands or ducts.
- i. Reduction of dislocations of, and excision of, the temporomandibular joints.
- j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related Medically Necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

- k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when Medically Necessary following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17. Treatment of Temporomandibular Disorders

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and Prior Authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

- a. A Congenital, developmental or acquired deformity, disease or Injury caused the condition.
- b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care Provider rendering the service.
- c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the Durable Medical Equipment Coinsurance as outlined in the Schedule of Benefits. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to \$1,250 per calendar year.

18. Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the \$1,000,000 maximum lifetime benefit for transplants.

Limited to one transplant per organ per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease. Organ retransplantation, which applies to items b., e., f., and g. as listed below, is not a covered benefit.

- a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
 - ▶ Aplastic anemia
 - ▶ Acute leukemia
 - ▶ Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
 - ▶ Wiskott-Aldrich syndrome
 - ▶ Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
 - ▶ Hodgkins and non-Hodgkins lymphoma
 - ▶ Combined immunodeficiency

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- ▶ Chronic myelogenous leukemia
 - ▶ Pediatric tumors based upon individual consideration
 - ▶ Neuroblastoma
 - ▶ Myelodysplastic syndrome
 - ▶ Homozygous Beta-Thalassemia
 - ▶ Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
 - ▶ Multiple Myeloma, Stage II or Stage III
 - ▶ Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
- b. Parathyroid transplantation
- c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.
- d. Corneal transplantation (keratoplasty) limited to:
- ▶ Corneal opacity
 - ▶ Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
 - ▶ Corneal ulcer
 - ▶ Repair of severe lacerations
- e. Heart transplants will be limited to the treatment of:
- ▶ Congestive Cardiomyopathy
 - ▶ End-Stage Ischemic Heart Disease
 - ▶ Hypertrophic Cardiomyopathy
 - ▶ Terminal Valvular Disease
 - ▶ Congenital Heart Disease, based upon individual consideration
 - ▶ Cardiac Tumors, based upon individual consideration
 - ▶ Myocarditis
 - ▶ Coronary Embolization
 - ▶ Post-traumatic Aneurysm
- f. Liver transplants will be limited to the treatment of:
- ▶ Extrahepatic Biliary Atresia
 - ▶ Inborn Error of Metabolism
 - Alpha -1- Antitrypsin Deficiency
 - Wilson's Disease
 - Glycogen Storage Disease
 - Tyrosinemia
 - ▶ Hemochromatosis
 - ▶ Primary Biliary Cirrhosis
 - ▶ Hepatic Vein Thrombosis
 - ▶ Sclerosing Cholangitis
 - ▶ Post-necrotic Cirrhosis, Hbe Ag Negative
 - ▶ Chronic Active Hepatitis, Hbe Ag Negative
 - ▶ Alcoholic Cirrhosis, abstinence for 12 or more months

- ▶ Epithelioid Hemangioepithelioma
 - ▶ Poisoning
 - ▶ Polycystic Disease
- g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.
- h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.
- i. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants section A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan Provider. Benefits are not available for Maintenance Therapy.

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:

- ▶ Reconstruction of the breast on which a mastectomy was performed;
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ▶ Prostheses (see DME in section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized by the Health Plan.

B. Institutional Services

Covers inpatient and outpatient Hospital services and Skilled Nursing Facility services that are necessary for the admission, diagnosis and treatment of a patient when provided by a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Health Plan may require that the hospitalization be Prior Authorized.

1. Inpatient Care

- a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription drugs administered during the Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.
- b. Licensed Skilled Nursing Facility: Must be admitted within twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must

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be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Benefits include prescription drugs administered during the Confinement. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.

- c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for Dental Care: Covered if services are provided to a Participant who is under five years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2. Outpatient Care

Emergency Care: First aid, accident or sudden illness requiring immediate Hospital services. Subject to the Copayment described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the Copayment.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic Testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

Participants should contact the Health Plan prior to any services to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e).

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided pursuant to an Emergency detention or on an

Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

- 1) Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1. The charges for such drugs will not be applied the maximum benefit available for any mental health, alcohol or drug abuse services.
- 2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the Provider by the Health Plan.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for Durable Medical Equipment. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.
- Insulin infusion pumps, limited to one pump in a calendar year and You must use the pump for thirty (30) days before purchase.

All Durable Medical Equipment purchases or monthly rentals must be Prior Authorized as determined by the Health Plan.

(Glucometers are available through the PBM. Refer to Section D. for benefit information.)

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, medical supplies and Durable Medical Equipment will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. All purchases or monthly rentals must be Prior Authorized as determined by the Health Plan. The following supplies and equipment will be covered:

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment such as, but not limited to: wheelchairs, hospital-type beds, and artificial respiration equipment.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

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- IUDs.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit.
- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, up to a maximum payment of \$1,000 per hearing aid. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Ostomy and catheter supplies.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids, the out-of-pocket costs will apply to the annual out-of-pocket maximum for Durable Medical Equipment.

4. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

- a. Emergency or Urgent Care. Non-urgent follow-up care out of the Service Area must be Prior Authorized or it will not be covered; and
- b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, pursuant to Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to

the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

5. Coverage of Newborn Infants with Congenital Defects and Birth Abnormalities

Pursuant to Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM)

You must obtain benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, You may need to make a claim as described in the paragraph below.

If You do not show Your PBM identification card at the pharmacy at the time You are obtaining benefits, You may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, You may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the Department. Contact the PBM if You have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the Health Plan.

1. Prescription Drugs

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed Illness or Injury; and are purchased from a PBM Network Pharmacy after a Copayment or Coinsurance amount, as described in the Schedule of Benefits. A Copayment will be applied to each prescription dispensed. The PBM may lower the Copayment amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual out-of-pocket maximum applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket maximum, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual out-of-pocket maximum as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket maximum, all family members will have satisfied the annual out-of-pocket maximum for that calendar year. The

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Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket maximum. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual out-of-pocket maximum for Level 1 and Level 2 Formulary prescription drugs.

The Health Plan, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, Confinement, emergency room visit or Urgent Care setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, Confinement, emergency room visit or Urgent Care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, Self-Administered Injectable).

Where a Medicare prescription drug plan is the primary payor, the Participant is responsible for the Copayment plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

Notwithstanding the exclusion in Section IV., 12., (b) for Participants in the Wisconsin Public Employers' group, the PBM will pay prescription drug benefits for Medicare eligible members as secondary, regardless of whether or not the Participant is actually enrolled in a Medicare Part D prescription drug plan.

Prescription drugs will be dispensed as follows:

- a. In maximum quantities not to exceed a 30 consecutive day supply per Copayment.
- b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns).
- c. Single packaged items are limited to 2 items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d. Oral Contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual out-of-pocket maximum. Coverage is limited to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.
- f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.

- h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- i. Tablet Splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.
- j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.
- k. The PBM reserves the right to designate certain over the counter drugs on the Formulary.
- l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

2. *Insulin, Disposable Diabetic Supplies, Glucometers*

The PBM will list on the Formulary approved products. Prior Authorization is required for anything not listed on the Formulary.

- a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30 consecutive day supply for one prescription drug Copayment, as described on the Schedule of Benefits.
- b. Disposable Diabetic Supplies and Glucometers will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for prescription drugs.

3. *Other Devices and Supplies*

Other devices and supplies administered by the PBM that are subject to a 20% Coinsurance and applied to the annual out-of-pocket maximum for prescription drugs are as follows:

- ▶ Diaphragms
- ▶ Syringes/Needles
- ▶ Spacers/Peak Flow Meters

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. **The exclusions do not apply solely to the category in which they are listed except that subsection 11 applies only to the pharmacy benefit administered by the PBM.** Some of the listed exclusions may be Medically Necessary, but still are not covered under this plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

1. *Surgical Services*

- a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- b. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct Congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an Illness or accidental Injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
- c. Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
- d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2. *Medical Services*

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits section.
- b. Expenses for medical reports, including preparation and presentation.
- c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; (c) treatment of flexible flat feet; or (d) in connection with any of these except when prescribed by a Plan Provider who is treating the Participant for a metabolic or peripheral disease or if the skin or tissue is infected.
- d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits section.

- e. Work related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).
- f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.
- g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing illness.

3. Ambulance Services

- a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.
- b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits Section.

4. Therapies

- a. Vocational rehabilitation including work hardening programs.
- b. Maintenance Therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.
- c. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

- d. Physical fitness or exercise programs.
- e. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.
- f. Massage therapy.

5. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

- a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

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- b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits Section.
- c. All oral surgical procedures not specifically listed in the Benefits Section.

6. Transplants

- a. Transplants and all related services, except those listed as covered procedures.
- b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.
- c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.
- d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
- e. All separately billed donor-related services, except for kidney transplants.
- f. Non-human organ transplants or artificial organs.

7. Reproductive Services

- a. Infertility services which are not for treatment of Illness or Injury (i.e., which are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.
- b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
- c. Services for storage or processing of semen (sperm); donor sperm.
- d. Harvesting of eggs and their cryopreservation.
- e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
- f. Implantable birth control devices (for example, Norplant).
- g. Surrogate mother services.
- h. Maternity services received out of the Plan Service Area in the ninth month of pregnancy, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control (for example, family emergency)).
- i. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

8. Hospital Inpatient Services

- a. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

- b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.
- c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

9. Mental Health Services/Alcohol and Drug Abuse

- a. Hypnotherapy.
- b. Marriage counseling.
- c. Residential care except transitional care as required by Wis. Stat. § 632.89.
- d. Biofeedback.

10. Durable Medical or Diabetic Equipment and Supplies

- a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.
- c. Medical supplies and Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for an hearing impairment); and self-help devices not Medically Necessary, as determined by the Health Plan, including, but not limited to, shower chairs and reaches.
- d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.
- e. Equipment, models or devices that have features over and above that which are Medically Necessary for the Participant will be limited to the standard model as determined by the Health Plan. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the Participant's condition nor is the existing equipment, models or devices in need of repair or replacement.
- f. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Health Plan.
- g. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.
- h. Customization of buildings for accommodation (for example, wheelchair ramps).

11. Outpatient Prescription Drugs – Administered by the PBM

- a. Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

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- b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.
- c. Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.
- d. Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).
- e. Anorexic agents.
- f. Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.
- g. All over the counter drug items, except those designated as covered by the PBM.
- h. Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- i. Charges for injectable medications, except for Self-Administered Injectable medications.
- j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.
- k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l. Infertility and fertility medications.
- m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.
- n. Charges for spilled, stolen or lost prescription drugs.

12. General

- a. Any additional exclusion as described in the Schedule of Benefits.
- b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.
- c. Treatment, services and supplies for which the Participant: (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

- d. Injury or Illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
- e. Treatment, services and supplies for any Injury or Illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.
- f. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.
- g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- h. Treatment, services or supplies used in educational or vocational training.
- i. Treatment or service in connection with any Illness or Injury caused by a Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j. Care provided to assist with activities of daily living (ADL).
- k. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.
- l. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.
- m. Custodial, nursing facility (except skilled), or domiciliary care. This includes community re-entry programs.
- n. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of Subscriber cancellation or non-payment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a Subscriber changing Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan's network. In this instance, the liability will remain with the previous insurer.
- o. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye following cataract surgery.

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- p. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and Medically Necessary or not required in accordance with accepted standards of medical, surgical or psychiatric practice.
- q. Charges for any missed appointment.
- r. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
- s. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- t. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:
 - 1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.
 - 2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.
 - 3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.
- u. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.
- v. Coma Stimulation programs.
- w. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.
- x. Any diet control program, treatment, or supply for weight reduction.
- y. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.
- z. Services to the extent a Participant receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation act, employer's liability insurance plan or similar law or act. Entitled means You are actually insured under Worker's Compensation.

- aa. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.
- ab. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.
- ac. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.
- ad. Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is Emergency ambulance transportation.
- ae. Sexual counseling services related to infertility and sexual transformation.
- af. Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not You choose to use those services.

B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.
2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental Injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.
3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.
4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.
5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and

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other Benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.
7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.
8. Lifetime policy maximum for transplant benefits: \$1,000,000.

Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

9. Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: \$2,000,000 (includes transplant benefits) per Health Plan.

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

1. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan at the same time. "Plan" and "This Plan" are defined below.
2. If this COB provision 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 Section D below, Effect on the Benefits of This Plan.

B. Definitions

In this section, the following words are defined as follows:

1. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined by the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the secondary plan will also be responsible for paying up to the maximum benefit allowed for its plan. This will not duplicate benefits paid by the primary plan.

2. "Claim Determination Period" means 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 COB provision or a similar provision takes effect.
3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:
 - a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). 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. Each contract or other

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arrangement for coverage under a. or b. is a separate Plan. Also, 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": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

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 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 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" means the part of your group contract that provides benefits for health care and pharmaceutical expenses.

C. Order Of Benefit Determination Rules

1. General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

- a. the other Plan has rules coordinating its benefits with those of This Plan; and
- b. both those rules and This Plan's rules described in subparagraph 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 or Participant are determined before those of the Plan which covers the person as a Dependent of an employee or Participant.

- b. Dependent Child/Parents Not Separated or Divorced

Except as stated in subparagraph 2., c. below, 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 rule described in 1. above 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 the 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 of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C., 2., b.

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

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule d. is ignored.

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:
 - i) 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.
 - ii) 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 The Plan

1. When This Section Applies

This Section D. applies when, in accordance with Section 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 section. Such other Plan or Plans are referred to as "the other Plans" in subparagraph 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 COB provision; 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 COB provision, 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

The Health Plan has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under This Plan must give the Health Plan 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, the Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. The Health Plan 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 the Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or

3. other organizations.

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

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations.

Each Participant agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the Health Plan and/or PBM but also disclosures to:

1. Health care Providers as necessary and appropriate for treatment;
2. Appropriate Department of Employee Trust Funds employees as part of conducting quality assessment and improvement activities, or reviewing the Health Plan's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations;
3. The tribunal, including an independent review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The Health Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this plan (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the Health Plan, each Participant shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The Health Plan may employ a professional staff to provide case management services. As part of this case management, the Health Plan reserves the right to recommend that a Participant consider receiving treatment for an Illness or Injury which differs from the current treatment if it appears that:

- a. the recommended treatment offers at least equal medical therapeutic value; and
- b. the current treatment program may be changed without jeopardizing the Participant's health; and
- c. the charges incurred for services provided under the recommended treatment will probably be less.

If the Participant or his/her authorized representative and the attending physician agree, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback,

acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

D. Disenrollment

No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance coverage is forfeited if a Participant assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

Change to an alternate Health Plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

The Department may at any time request such documentation as it deems necessary to substantiate Subscriber or Dependent eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent dual-choice enrollment periods. Re-enrollment in the Health Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery Of Excess Payments

The Health Plan and/or PBM might pay more than the Health Plan and/or PBM owes under the policy. If so, the Health Plan and/or PBM can recover the excess from You. The Health Plan and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the Health Plan and/or PBM.

Each Participant agrees to reimburse the Health Plan and/or PBM for all payments made for benefits to which the Participant was not entitled. Reimbursement must be made immediately upon notification to the Subscriber by the Health Plan and/or PBM. At the option of the Health Plan and/or PBM, benefits for future charges may be reduced by the Health Plan and/or PBM as a set-off toward reimbursement.

F. Limit On Assignability Of Benefits

This is Your personal policy. You cannot assign any benefit to other than a physician, Hospital or other Provider entitled to receive a specific benefit for You.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each Participant agrees that the insurer under these Uniform Benefits, whether that is a Health Plan or the Public Employee Trust Fund, shall be subrogated to a Participant's rights to damages, to the

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extent of the benefits the insurer provides under the policy, for Illness or Injury a third party caused or is liable for. It is only necessary that the Illness or Injury occur through the act of a third party. The insurer's rights of full recovery may be from any source, including but not limited to:

- The third party or any liability or other insurance covering the third party
- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- Any medical payments, no-fault or school insurance coverages which are paid or payable.

Participant's rights to damages shall be, and they are hereby, assigned to the insurer to such extent.

The insurer subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the insurer's prior written consent shall be deemed to prejudice the insurer's rights. Each Participant shall promptly advise the insurer in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the insurer such additional information as is reasonably requested by the insurer. The Participant agrees to fully cooperate in protecting the insurer's rights against a third party. The insurer has no right to recover from a Participant or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the Participant's or insured's comparative negligence. If a dispute arises between the insurer and the Participant over the question of whether or not the Participant has been "made whole", the insurer reserves the right to a judicial determination whether the insured has been "made whole".

In the event the Participant can recover any amounts, for an Injury or Illness for which the insurer provides benefits, by initiating and processing a claim pursuant to a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the Participant shall either assert and process such claim and immediately turn over to the insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the insurer immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof Of Claim

As a Participant, it is Your responsibility to notify Your Provider of Your participation in the Health Plan and PBM.

Failure to notify a Plan Provider of Your membership in the Health Plan may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If You receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Health Plan, clearly indicating the Health Plan's name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of Your claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the Health Plan and/or PBM does not receive the claim within 12 (twelve) months, or if later, as soon as reasonably possible, after the date the service was received, the Health Plan and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating Health Plans and the PBM are required to make a reasonable effort to resolve members' problems and complaints. If You have a complaint regarding the Health Plan's and/or PBM's administration of these benefits (for example, denial of claim or Referral), You should contact the Health Plan and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, You may file a written Grievance with the Health Plan and/or PBM. Contact the Health Plan and/or PBM for specific information on its Grievance procedures.

If You exhaust the Health Plan's and/or PBM's Grievance process and remain dissatisfied with the outcome, You may appeal to the Department by completing an ETF complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department.

You may also request an independent review per Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. You have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision has been rendered. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.