



Group Administrative Manual

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1. CONTACT INFORMATION

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GENERAL CONTACT INFORMATION

Phone Numbers

Physicians Plus Insurance Corporation (608) 282-8900 or (800) 545-5015
Sales Department (608) 282-8940
Member Service Department..... (608) 282-8900 or (800) 545-5015
TDD (608) 260-7998
Billing (800) 916-9162
Enrollment..... (800) 916-9162

Fax Numbers

Member Service Fax Number..... (608) 258-1902
Billing Fax Number..... (972) 232-8811
Enrollment Fax Number (972) 232-8807
Sales/Service Fax Number..... (608) 258-1906
Pharmacy Fax Number (608) 258-1905

E-mail addresses

Sales Information sales@pplusic.com
Group Service Information..... groupservice@pplusic.com

Mailing addresses

- Corporate Headquarters
Physicians Plus Insurance Corporation
22 East Mifflin Street, Suite 200
P.O. Box 2078
Madison, WI 53703
(608) 282-8900 or 1-800-545-5015
- Premium Billing Mailing Address
Physicians Plus Insurance Corporation
P.O. Box 3057
Milwaukee, WI 53201-3057
(800) 916-9162
- Enrollment Mailing Address
Physicians Plus Insurance Corporation
P.O. Box 269001
Plano, TX 75026-9001

2. CONTRACT INFORMATION

PLEASE ADD THE FOLLOWING TABS if you are printing this manual:

- a. GROUP MASTER CONTRACT
- b. CURRENT SCHEDULE OF BENEFITS
- c. RIDERS/AMENDMENTS
- d. [MEDICAL CERTIFICATE OF COVERAGE](#)
- e. [MEMBER HANDBOOK](#)
- f. OTHER

3. GO-TO HEALTHY CHOICES

Physicians Plus has an innovative new resource to help your employees live healthier, happier lives! GO-TO Healthy Choices is an online personal health manager designed to put your employees in direct control of their health. It's convenient, effective and fun and is now built in to all Physicians Plus health plans (for members 18–65). GO-TO Healthy Choices is unique to each individual user because it's based on their personal health histories, practices and goals.



Taking an initial health risk assessment (HRA) is the entry point to GO-TO Healthy Choices and provides a snapshot of overall health. Completion of the confidential, online HRA results in a personalized plan via e-mail for making healthier lifestyle choices (paper versions of the HRA and resulting plan are available if needed).

The next step is really up to the individual. If it's setting new health priorities, GO-TO Healthy Choices can help. It delivers interactive programs on nutrition, weight management and physical activity, managing stress, smoking cessation and managing chronic conditions like back pain, diabetes and others. Users can take advantage of as many or as few programs as they wish to make positive health changes. It's all completely private and confidential, and each GO-TO Healthy Choices participant sets their own pace!

The most important reward for GO-TO Healthy Choices users is better health and more active living. Physicians Plus provides a financial incentive, too. Physicians Plus will send a \$25 Good Health Bonus reward to all members who take the HRA. Participants who also complete two Lifestyle Improvement or Condition Management programs as follow-up to the HRA can earn another \$75 from the Good Health Bonus. That's \$100 in rewards, just for taking a few steps toward a healthier lifestyle!

Encourage your employees to check out GO-TO Healthy Choices and get moving toward a healthier, more active life!

Get Started Today!

1. Log into [GO-TO](#). (You must have or create a GO-TO account to use GO-TO Healthy Choices.)
2. Click the GO-TO Healthy Choices icon. Make sure to turn off your pop up blocker on your Internet tool bar.
3. Choose language preference by clicking on the "English" or "Spanish" button. You will only have to choose your language preference the first time you access GO-TO Healthy Choices.
4. Once you log in to GO-TO and click on GO-TO Healthy Choices you will be linked to the HealthMedia site.
5. Start Your HealthMedia Succeed HRA

4. GOOD HEALTH BONUS

Healthy Choices. Big Rewards.

Want to lose 20 pounds? Let's start today. Need to quit smoking? We can help. Whether you're interested in taking a class, joining Weight Watchers, or eating healthier, the Good Health Bonus program is your first step to bigger rewards for healthier choices.

Join a Health & Fitness Facility.

A regular exercise routine is important to maintaining a more active and healthy lifestyle. Physicians Plus offers a health & fitness facility reimbursement as part of its Good Health Bonus program. Members with single contracts can receive up to \$100 per year. Members with family contracts can receive up to \$200 per year per family.

Take a class.

From discovering the joys and challenges of childbirth to learning how to meditate, Physicians Plus and its affiliated partner programs offer Good Health Bonus classes to learn about specific medical conditions as well as general health and diet instructions. No matter where you are in life, the classes offered through the Good Health Bonus program will keep everyone on the move and offer a wealth of healthy living knowledge.

Class participants must first pay the course registration fee. Upon completion of a course, the instructor will complete and submit the form needed to receive reimbursement of up to \$100 or the total course fee, whichever is less. Members with single contracts can receive up to \$100 per year. Members with family contracts can receive up to \$200 per year per family. Click **Approved Classes**, and you're sure to find something that's just right for your lifestyle.

To be eligible for reimbursement:

- Participants must attend the entire class or 75% of classes offered in a series.
- Courses must be provided by facilities approved by Physicians Plus. Please note that not all courses that a facility offers are approved courses. Courses may be cancelled or rescheduled if minimum enrollment is not achieved.
- You must be at least 18 years old (except for babysitting classes).

To receive reimbursement for your Good Health Bonus class, simply download the [Good Health Bonus Redemption Form](#) and bring it with you to class. You will need your instructor's signature on the form before mailing it to the address listed on the form for reimbursement. If you prefer, you may also get this form from your instructor the day of the class.

Join Weight Watchers.

Weight Watchers® has been recognized for over 37 years as a safe and sensible way to manage weight. Due to its success rate in meeting and maintaining individualized weight goals, and its strong educational component of sensible nutrition and exercise, we are pleased to offer Weight Watchers as a part of our Good Health Bonus program.

Eat Healthier.

With the Eat Healthy Rebate program from Physicians Plus Insurance Corp., members can now apply their Good Health Bonus rebate to the cost of a produce share from MACSAC farms!

Physicians Plus members can receive rebates of up to \$100 for single contracts and \$200 for family contracts. Life is better when you eat plenty of locally grown, organic veggies. Physicians Plus just wants to make it even more rewarding.

Participate in GO-TO Healthy Choices.

Introducing GO-TO Healthy Choices! Our new personal health manager provides anytime online access to health risk assessment, lifestyle improvement and condition management programs for Physicians Plus members 18 to 64.

**Incentives and Rewards**

Take the initial Health Risk Assessment and earn \$25. Then complete two Lifestyle Improvement and/or Condition Management programs and their 30-, 90-, and 180-day post-program surveys and earn an additional \$75. (State employees earn \$25 and \$75 Good Health Bonus limit increases, instead of cash back, for completing the assessment and two management programs).

Please allow 6-8 weeks to receive your Good Health Bonus reimbursement reward.

5. PLUS PERKS

Healthy Choices. Big Rewards.

Plus Perks offers you an abundance of choices for enhancing your life and your health. With Plus Perks, members receive discounts on healthful products and services such as eyeglasses, complementary medicine and massage therapy.

All Physicians Plus health plan members are automatically eligible for Plus Perks discounts. No sign-up is necessary. Simply show your Physicians Plus Member ID card at the participating business to earn your discount.

Participating businesses apply all discounts at the time of purchase. Physicians Plus coordinates the program with eligible businesses. We do not charge our members to participate and do not build any costs into your health care premium.

When you combine Plus Perks with your Physicians Plus health plan membership you enjoy even more benefits for your health. Plus Perks offers you discounts on a wide assortment of health-related products and services from area businesses. Just look at this as your opportunity to try something new. Add more to your life starting today, with Plus Perks from Physicians Plus.

Disclaimer

Physicians Plus Insurance Corporation does not endorse or make any representation or guarantee regarding any product, service, or business offered through the Plus Perks program. You must make your own judgment about each product, service, and participating business, including the appropriateness and quality of each product and service. You are also solely responsible for paying the costs and fees for any services and products that you choose to receive. By participating in the Plus Perks program, you are agreeing that Physicians Plus Insurance Corporation has no responsibility or liability for your purchase or use of any offered product or service or for the actions of any participating business.

6. NURSE PLUS

866-PPLUSRN (866-775-8776)

NursePlus provides direct communication with a qualified professional who is ready to provide health care answers and assistance for you and your family whenever you need it. For instance, if you are not sure if emergency care is called for, just ask. If you want clarification regarding a prescription or medical procedure, informed advice is only a phone call away all day, every day.

Do you have questions about instructions from your doctor or pharmacist? Or perhaps you need help understanding the side effects of certain medications. From the day-to-day health and medical questions to more serious matters, there is a source of information for whatever ails you. It's called NursePlus.

NursePlus is prepared to answer the questions that are important to you around the clock, seven days a week. Our registered nurses are always on the other end of your telephone to speak with you and explain all you need to know to feel confident about your current medical condition. Our NursePlus professional reviews your symptoms thoroughly and provides advice. If your condition requires further medical attention, NursePlus may advise you to call your doctor or seek immediate care.

When you call, we ask for basic information in order to maintain accurate records. If you need to make a medical decision, NursePlus helps you decide if your health care event requires urgent or emergency medical care. NursePlus is not a 911 emergency line or source for diagnosis.

NursePlus supports your relationship with your physician. We offer professional, caring nurses who can help you understand risk factors and treatment options and discuss up-to-date clinical guidelines. If you have to make difficult decisions, our registered nurses have clinical guidelines and resources on hand as well as immediate access to more information via computer.

Audio Message Center

To learn more about your personal health care needs including specific medical topics or conditions, NursePlus provides members with comprehensive audio health messages.

Members can access this automated service from anywhere at anytime. We offer more than 700 recorded, clinically based messages for your review 24 hours a day, seven days a week. Asthma in Children and Diabetes are just two examples of more than 700 health topics available in our [Audio Message Center](#).

To learn more about these and other topics, call 866-PPLUSRN (866-775-8776).

7. GENERAL INFORMATION

IDENTIFICATION CARDS

The ID card includes all family members enrolled on the policy, the PCP for each member and the member numbers. The card also includes information on copays, deductibles and coinsurance if applicable. All Physicians Plus members will receive an ID card at the time of enrollment. Please see the sample ID card below.

SAMPLE FRONT and BACK

Group # XXXXXX	HMO/POS/PPO YR: 2009
<u>MEMBER #</u>	<u>MEMBER NAME</u>
123456789 01	JANE DOE
PCP: Dr. Smith, MD	
123456789 02	JAMES DOE
PCP: Dr. Jones, MD	
123456789 03	BILLY DOE
PCP: Dr. Jones, MD	
123456789 04	SARAH DOE
PCP: Dr. Jones, MD	
COPAYS: OV: \$15/\$35	ER: \$150 HOS: \$500
RX: \$5/\$25/50%	DN: Y/N

PLEASE READ YOUR POLICY INFORMATION FOR DETAILS

Physicians Plus Insurance Corporation

Medical Claims

Physicians Plus Insurance Corp.
P.O. Box 269017
Plano, TX 75026



Pharmacy Claims

Physicians Plus Insurance Corp.
P.O. Box 2078
Madison, WI 53701-2078
PCN#: 00710000
BIN# 600428



Visit www.healthychoicesbigrewards.com and use GO-TO to access your person health plan information

Member Service, 7am-5pm, M-F (608)282-8900, (800) 545-5015 or ppicinfo@pplusic.com
NursePlus 24-hr. medical advice information line@866) PLUSRN

Please contact Physicians Plus Member Service within 48 hours of any emergency or hospital admission or medical care received outside the service area.

P+3993-0701

MEMBER SERVICES DEPARTMENT

Our Member Service staff is available at (608) 282-8900 ext. 7802 or (800) 545-5015 ext. 7802 from 7:00 am to 5:00 pm Monday thru Friday to answer question and solve any problems your employees may have. Our Member Service Department can assist with any of the following questions or concerns:

- Coverage and Benefits;
- Selecting or changing a primary care physician;
- Pre-certification and/or referrals for specific services;
- Claims;
- Eligibility;
- ID Cards;
- Member materials;
- Change of address and/or telephone number;
- Go-To questions or issues;
- Good Health Bonus
- A complaint or concern a member has been unable to resolve.

CHOOSING A PCP

Each member of Physicians Plus Insurance Corporation **must choose** a primary care physician (PCP) at the time of enrollment. PCP's provide general medical services, refer members to a specialist if necessary, and coordinate our member's overall health care. PCP's are trained to diagnose and treat a wide range of diseases and illnesses. They work directly with specialty providers to coordinate specialized care if needed. Primary care physicians include family practitioners, internal medicine doctors, pediatricians and in some cases, obstetricians/gynecologists.

Family practitioners are trained to provide medical care for all ages. Some family practitioners provide obstetric care.

Internal medicine doctors are trained to provide general medical care for adults.

Pediatricians are trained to provide general medical care for infants, children, adolescents and young adults.

Obstetricians and gynecologists specialize in health care for women, including care during and after pregnancy.

*A PCP must be chosen from the most current list of participating PCP's listed Provider Directory or on our on line directory at www.pplusic.com. Each family member must choose a PCP and each family member may choose a different PCP. Members may also change their PCP designation by calling our Member Service department or via GoTo. All PCP changes are effective the first of the month following Physicians Plus notification.

* This does not apply to PPO members.

8. PRIOR AUTHORIZATION

Some services obtained from a Provider other than a PCP require written approval by Physicians Plus **before** services are provided. The members PCP will fill out the information needed on the Prior Authorization form and then send it to Physicians Plus for approval. Physicians Plus will send a letter to the member and the provider when a decision is made whether to approve or deny the Prior Authorization. Coverage is based on eligibility and benefits at the time services are rendered. If a Prior Authorization is required but not obtained, Physicians Plus will not pay for the treatment(s), services or supplies provided.

ALL inpatient care including hospitalizations, hospital rehabilitation, hospice care and skilled nursing facilities require PRIOR AUTHORIZATION before services are provided. If prior authorization is not obtained when required, services will not be covered. Please contact our Member Service department if you have questions regarding our prior authorization requirements. Examples of services that require precertification are:

- ‡ All treatment, services and supplies being requested and/or performed by any **NON-Participating Provider**, including but not limited to Physicians, clinics, Hospitals and pharmacies;
- ‡ All care (other than Emergency Medical Care) received out of the Service Area;
- ‡ All Hospital admissions and/or inpatient care;
- ‡ Outpatient/Ambulatory surgeries that may be considered cosmetic (not a covered benefit), including but not limited to, reduction mammoplasties, blepharoplasties and septo-rhinoplasties;
- ‡ Dental care that requires treatment, services or supplies at an outpatient Hospital or Ambulatory Surgery Center;
- ‡ Medical Supplies: Including diabetic supplies, Durable Medical Equipment, supplies and Prosthetic Device purchased over \$5000;
- ‡ Home care services, supplies and therapies;
- ‡ Hospice care;
- ‡ Skilled nursing care;
- ‡ Transplants (All);
- ‡ Behavioral Health (Nervous or Mental Illness) and Alcohol and/or Drug Abuse (Chemical Dependency) services. To obtain Prior Authorization and/or find a Participating Provider, contact the Behavioral Health Case Management and Consultation Services at (608) 282-8960 or (800) 683-2300 AODA) services;

Planned hospital admissions at non-participating Hospitals WILL NOT be authorized. Nonparticipating hospitals include, but are not limited to, Mayo Clinic and Hospitals, St. Mary's Hospital (Madison) and Mercy Hospital in Janesville, and/or any other non-participating hospital.

The member should confirm prior authorization approval by contacting our Member Service department the member is responsible for any prior authorization required. *If prior authorization was required but not obtained payment of the claim will be the member's responsibility.* For additional information, please refer to your Medical Certificate of Coverage.

9. ELIGIBILITY

ELIGIBLE EMPLOYEE: A person is an Eligible Employee if he/she:

- (A) Appears on the Policyholder's regular payroll records (excluding temporary and/or leased employees);
- (B) is scheduled to perform the duties of his/her job with the Policyholder for at least the minimum number of hours per week as required on the policyholders current application for coverage (the required minimum shall not exceed 30 hours per week);
- (C) is Actively at Work (except where immediate coverage is required under Ins. 6.51 of the Wisconsin Administrative Code or HIPAA); and
- (D) has completed the waiting period, if any, for coverage to be effective as specified by the Policyholder's application for coverage.

ELIGIBLE DEPENDENTS include any of the following who meet the other requirements of the Policy (such as age limits): a covered employee's spouse, child, stepchild, adopted child, Legal Ward, and grandchild (so long as the grandchild's parent is a covered dependent and under age 18), and a child placed for adoption with the Eligible Employee.

For the employee's child, stepchild, adopted child, Legal Ward, or child placed for adoption with the employee to be eligible, the child must not exceed the Maximum Dependent age of 19 or, so long as the dependent is a Full Time Student, 25 (except for a mentally or physically disabled child as described in the "DISENROLLMENT AND WHEN COVERAGE ENDS" section of this Certificate).

EFFECTIVE DATES OF COVERAGE

To be enrolled, coverage must be applied for and approved by Physicians Plus and the required premium must be received by Physicians Plus. Except in cases of continuation coverage, Eligible Dependents can be covered under this Policy only if the Eligible Employee is covered. Except for Late Enrollment (discussed below) and the special enrollment period (discussed below), coverage will become effective on the following dates:

For an Eligible Employee, coverage generally will be effective on the latest of:

- (A) The effective date of the Group Master Policy between Physicians Plus and the Policyholder; and
- (B) When the employee has satisfied all the requirements to be an Eligible Employee, including completion of any waiting period specified by the Policyholder in its application for coverage.

Coverage will be delayed if the Eligible Employee is not Actively at Work on the date coverage otherwise would begin (unless that date falls on a non-working day and the employee was Actively at Work on the immediately preceding working day, or except as required by Ins. 6.51 or HIPAA). If coverage is delayed for this reason, coverage for the Eligible Employee and his enrolled Eligible Dependents will begin on the next day the eligible employee is Actively at Work.

Coverage also will not be effective if the Eligible Employee fails to apply for coverage: (i) during the policyholder's annual enrollment period, or (ii) for an employee who was not eligible during the annual enrollment period, within 31 days of beginning work for the minimum number of hours

per week that the Policyholder requires for an employee to be eligible for health insurance coverage. In those situations, the employee will be considered to be a Late Enrollee.

For an Eligible Dependent, coverage will be effective on:

- (A) The date the Eligible Employee is enrolled for coverage in the case of dependents who then qualify as eligible dependents;
- (B) The date of the Eligible Employee's marriage in the case of the spouse and any stepchild acquired on that date;
- (C) The date of birth of the Eligible Employee's natural-born child;
- (D) the date a child is placed for adoption (as defined in Section 632.896(1) of the Wisconsin Statutes) in the eligible employee's home or the date that a court issues a final order granting adoption of the child to the eligible employee, whichever occurs first;
- (E) The date of the court order appointing the covered employee as guardian in the case of a Legal Ward;
- (F) The date of birth for a child born to an Eligible Employee's covered child who is under the age of 18.

Except for newborns, adopted children and children placed for adoption with the Eligible Employee (which is discussed below), an application must be received by Physicians Plus within 31 days of eligibility or the individual will be subject to a waiting period unless he/she is considered for a special enrollment. See "SPECIAL ENROLLMENT PERIODS" AND "LATE ENROLLMENT" below.

SPECIAL RULES FOR NEWBORNS AND ADOPTED CHILDREN

Newborns. Coverage for a newborn of an Eligible Employee who is covered under the Policy is effective from the moment of birth.

In the event of a newborn, please submit Your application for coverage of the newborn to Physicians Plus as soon as possible. If more than one insurance Policy will cover the newborn, please notify all applicable plans as soon as possible. If Physicians Plus is obligated to cover a newborn, all requirements of the Policy must be covered for services to be covered, including authorizations for inpatient services for the birth of the child.

If coverage of the newborn results in an increased premium, You must submit Your application and the required premiums to Physicians Plus within 60 days. If You do not comply with that 60-day requirement, coverage of the newborn will terminate after that 60 days unless, within one year of the birth, You apply and pay Physicians Plus all back premiums plus interest at a rate of 5.5%. If coverage terminates for the newborn, he/she will be considered a late entrant and must serve a 12-month waiting period.

Adopted Children. Coverage for an adopted child is effective on the date that a court makes a final order granting adoption of the child to the Eligible Employee. Coverage for a child who is placed in the Eligible Employee's home for adoption is effective on the date the child is "placed for adoption" as defined in Section 632.896(1) of the Wisconsin Statutes. You must notify Us that the child is adopted or placed for adoption and pay Us any premium required to provide coverage for the child within 60 days or the child will be considered a late entrant and must serve a 12-month waiting period.

SPECIAL ENROLLMENT PERIODS

If an Eligible Employee or an Eligible Dependent does not apply for coverage when initially eligible due to having other Creditable Coverage, he/she may be eligible for a special enrollment period if: (1) he/she was covered under health insurance coverage at the time of his/her initial eligibility; (2) he/she stated in writing at the time of initial eligibility that other health insurance coverage was the reason for declining enrollment; and (3) he/she applies for coverage no later than 31 days after the date on which the other coverage is exhausted or terminated.

NEW April 1, 2009: As required by Federal law (Children's Health Insurance Program or CHIP) an eligible employee may defer coverage under the employer's health plan if s/he is covered under medical assistance, Medicaid, BadgerCare or CHIP. If the employee or eligible dependent loses coverage under either of those plans or becomes eligible for a premium assistance subsidy program the employee OR dependent may elect coverage under Special Enrollment by submitting an application to the employer within 60 days of the loss of eligibility or the date it is determined the employee or eligible dependent is eligible for coverage under the premium assistance program. The employee OR dependent will have to provide evidence of their termination and/or eligibility to the employer and/or health plan.

EXAMPLES OF SPECIAL ENROLLMENTS: WE MUST receive the application for a special enrollment within 31 days of the SPECIAL ENROLLMENT event or the members will be considered a late entrant. * Please don't wait for a certificate of creditable coverage to send in the Enrollment forms.

Group Special Enrollments and Coverage Changes

Event	Guideline	Effective Date	Forms Needed
Marriage	Employee, spouse and newly acquired dependents may apply or employee may add spouse and newly acquired dependents.	Date of Marriage	Group Application/Change Form
Birth	Employee, spouse and newborn may apply, or employee may add spouse and/or newborn. Other dependents can be added but may be considered late entrants.	Date of Birth of newborn child	Group Application/Change Form
Adoption	Employee, spouse and new dependent may apply, or employee may add spouse and/or new dependents.	Date of order for legal adoption or placement.	Group Application/Change Form and copy of court order placing child for adoption.
Legal Ward	Employee may add legal ward to existing coverage.	Date of legal custody or placement of legal ward.	Group Application/Change Form and copy of court order placing child with employee or spouse.

Divorce	Employee and eligible insured dependents may join the group plan if losing coverage due to divorce.	Day/date following loss of other coverage.	Group Application/Change Form and proof of loss of other coverage (certificate of creditable coverage, letter from previous carrier, continuation notice*).
Loss of other Creditable Coverage	Eligible employee, spouse and dependents may join the group plan.	Day/date following loss of other coverage.	Group Application/Change Form and proof of loss of other coverage (certificate of creditable coverage, letter from previous carrier, continuation notice*).
Significant increase in cost for spouses plan caused by group or insurer.	Employee and eligible insured dependents may join the group plan if losing coverage.	Date following the effective date of increase in premium for other plan.	Group Application/Change Form and proof of premium increase from other plan.
Move into or out of the service area	Employee and eligible insured dependents may change from a HMO plan to a POS or PPO plan if they move out of the service area	First of the month following the move.	Group Application/Change Form

Other Special Enrollment events may qualify if you have questions please contact your service representative.

LATE ENROLLMENT

A late enrollee is defined in the law as an individual who attempts to enroll under a plan at any time other than 1) during the period in which he or she is first eligible, or 2) during a special enrollment period.

Under the Health Insurance Portability and Accountability Act (HIPAA), insurers may not establish eligibility rules for acceptance or enrollment of an individual based on health-related factors. This means that insurers are not allowed to medically underwrite late enrollees to determine whether or not to issue coverage based on their health status.

If an Eligible Employee or his/her Eligible Dependent does not apply for coverage within 31 days of initially becoming eligible for coverage and does not qualify for special enrollment, the Eligible Employee and/or Eligible Dependent(s) will serve a 12-month waiting period, and coverage will be effective on the first day of the month following that waiting period. The 12-month waiting period will start on the first of the month following our receipt of the application.

It is therefore critical that employees and/or their dependents exercise caution when declining health insurance when it is first available. If coverage is waived, the employee or dependents face a 12 month waiting period if and when they apply for enrollment, unless they qualify for a special enrollment period. Any eligible employee not electing to enroll on your health insurance plan within the probationary period must sign a waiver. Please keep a copy of the waiver for your files and forward the original to our Enrollment Department.

10. ENROLLMENT

GO-TO is the Physicians Plus online enrollment application to assist Employers in administering their plan. What you can do with GO-TO:

- Add new employees and their eligible dependents
- Change subgroup
- Disenroll subscribers and dependents
- Order ID cards
- Change PCP
- Change address
- Download rosters
- Search invoices
- View benefits
- Send secure messages and more

See the online Users Manual for Go-To or contact your service representative.

If the transaction you need to process is not available on Go-To or if you do not have a Go-To account it is important to submit the Group Enrollment/Change form for the situations below.

How to submit the Group Enrollment/Change Form

1. Complete the Group Enrollment/Change Form and send the white copy to:

Physicians Plus Insurance Corporation
P.O. Box 269001
Plano, TX 75026-9001

2. Retain the yellow copy
3. Give the pink copy to the employee.

Please note that in no case will Physicians Plus consider the effective date of a termination of coverage to be more than 60 days prior to the date we are notified of the termination.

The Group Enrollment/Change Form is used for the following situations:

1. Adding a Dependent

When adding a dependent (e.g., a spouse or child), Sections 1, 2, 3, 4 and 5 must be completed, including:

- Dependent's name and address.
- Relationship to employee.
- Social Security number.
- Sex.
- Birthdate.
- Whether he or she is a full time student living out of area.
- Name and provider number of primary care physician. Please note: a member will not be enrolled without a PCP.
- Reason for addition, such as marriage, birth or loss of other coverage.

New dependents may be added by submitting a completed change form within 60 days of a birth or adoption or within 31 days of a marriage or qualifying event. Coverage is effective the date of birth or marriage.

2. Terminating a Dependent

When terminating a dependent, Sections 1, 2, 4 and 5 must be completed. In Section 3, indicate the effective date of the change, the reason the dependent is being removed from the plan, and check the "Delete dependents listed above" box. Terminating a dependent must be done in writing via the Group Enrollment/Change form.

3. Terminating an Employee

Complete Sections 1, 2 and 5. In Section 3, indicate the effective date the employee should be removed from the plan (per the Group Master Policy), the reason for the change, and check the "Cancel all coverage" box.

4. Change of Date of Birth

5. Legal Name Change

12. PRODUCTS & BENEFITS

Physicians Plus Insurance Corporation offers a wide variety of plans. If you wish to change plan designs please contact your service representative. The following is an overview of the plan types offered by Physicians Plus.

Health Maintenance Organization (HMO) A health maintenance organization (HMO) is defined by Wisconsin statute and provides comprehensive medical care. Persons insured by an HMO plan are referred to as members or enrollees. An HMO pays for and provides the medical care outlined in the policy. An HMO usually operates on a closed panel basis. This means the enrollees are required to seek care from a medical provider who is either employed by or under contract to the HMO. HMOs limit care to a specific geographic area.

Point-of-Service Plan (POS) A point-of-service plan (POS) is generally offered by HMOs and permits members/enrollees to choose providers who are not on the panel if the enrollees are willing to pay part of the cost. The plan permits members to make the choice at the time the services are needed. If an enrollee chooses a non-participating or non-HMO provider, he or she may have to pay a deductible and coinsurance.

Preferred Provider Organization/Plan (PPO/PPP) A preferred provider organization plan (PPO/PPP) or organization is defined by Wisconsin statute. The PPO provides a preferred national network much like an HMO and gives incentives to insured's to use preferred providers. For example, the plan may have a copayment provision in which the insurer pays 80% and the insured pays 20%. However, if insured's use the preferred providers, the insurer pays 90% rather than 80% of covered expenses.

- **Copay Plans** offer benefits with and without a copays for office visits and services.
- **Tiered Plans** offer benefits with and without copays for various levels of services with various levels of providers and specialists.
- **HealthShare Plans** combine traditional Deductibles with Coinsurance and Copays.
- **High Deductible Health Plans** offer benefits with deductibles and coinsurance. Some plans may qualify to be used in conjunction with a Health Savings Account.
- **Meriter Directed Plans** benefits are increased when members utilize the expertise of a Meriter affiliated facility.
- **Medicare Select Plans** offer Individual with Medicare A & B an option to fill the gap between Medicare payment and self pay.
- **Individual Plans** offer members not insured through an Employer Group many options to protect themselves at the level of coverage they choose. Individual plans are subject to medical underwriting approval.

13. GENERAL EXCLUSIONS & LIMITATIONS

THE FOLLOWING GENERAL EXCLUSIONS AND LIMITATIONS APPLY TO ALL SERVICES

This information on general policy exclusions and limitations is taken directly from the Medical Certificate of Coverage. For more detailed information please consult the Physicians Plus Insurance Corporation Medical Certificate of Coverage.

General Policy exclusions and limitations not listed elsewhere in this Policy are listed in this section. See specific benefits and services for additional exclusions and limitations.

Physicians Plus will not cover:

- a. Any services performed by a Non-Participating: Physician, Hospital, facility or other Provider.
- b. Any services for which Prior Authorization was required but not obtained. It is the Member's responsibility to obtain the proper Prior Authorization.
- c. Any treatment, services and supplies not specifically identified as being covered under this Policy; and any treatment, services and supplies required in connection with, in follow up to, or as a result of a treatment, service or supply not covered under this Policy.
- d. Paternity testing;
- e. Cytotoxic testing in conjunction with allergy testing;
- f. Hair analysis, unless lead or arsenic poisoning is suspected;
- g. Coma stimulation programs;
- h. Orthoptics (eye exercise training);
- i. Long term and/or Maintenance Care/Therapy;
- j. Massage therapy (except when provided during physical therapy for an Acute Illness or Injury);
- k. A second opinion by a Non Participating Provider;
- l. Eye glasses, contact lenses, sun glasses, frames and/or the fitting of frames (except as specifically listed in this certificate under the BENEFIT AND SERVICES section);
- m. Charges for telephone consultations by and between Providers;
- n. Charges for any missed appointments;
- o. Expenses for medical records and/or reports, including but not limited to, the preparation and presentation of these reports;
- p. Chelation therapy for arteriosclerosis;
- q. Complications related to cosmetic body piercing, tattooing, implants or other services or procedure that are not Medically Indicated or not performed by a licensed medical professional.
- r. Services and supplies that are not Medically Indicated and/or are not appropriate to the treatment of an Illness or Injury, as determined by Physicians Plus.
- s. Services and supplies provided while a Member's coverage was not in effect under this Policy (except in the extension of benefits provision of this Policy).
- t. Treatment, services and supplies that a third party (other than the Member's PCP) requires the Member to receive; services for which another party is liable as determined by Physicians Plus, including, but not limited to: Workers' Compensation, school-based programs, federally mandated programs, Medicare, work-related services including employment physicals, tests, and exams and exams requested or directed by a court of law. If benefits are paid or provided by Physicians Plus whenever this exclusion applies, Physicians Plus reserves all rights to recover the reasonable value of such benefits, including as provided in the section of this Certificate entitled PAYMENTS AND RECOVERY
- u. Services, supplies or other care for Injury or Illness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Certificate. If benefits subject to this provision are paid or provided by Physicians Plus,

Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in the section of this Certificate entitled OTHER POLICY PROVISIONS-SUBROGATION and REIMBURSEMENT.

v. Treatment and services for an Illness or Injury caused by atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile.

w. Treatment, services and supplies incurred in connection with any Injury or Illness arising out of, or in the course of, any employment for wage or profit for which an employer either is required to carry or does carry Workers Compensation insurance. If Worker Compensation or any similar law applies to the Member, this exclusion applies regardless of whether benefits under Workers Compensation or any similar law have been claimed, paid, waived or compromised. If benefits are paid or provided by Physicians Plus in a contested Workers' Compensation proceeding, or whenever Workers Compensation benefits may be payable, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in the section of this Certificate entitled OTHER POLICY PROVISIONS- WORKERS COMPENSATION.

x. Treatment and services furnished by the U.S. Veterans Administration except when coverage is required under applicable federal law.

y. Treatment and services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or facility or while in the custody of law enforcement officials, except as required by state or federal law. Persons who are injured or become ill while outside of the institution or facility and while on work release are not considered to be held, detained or imprisoned if they are otherwise eligible Members.

z. Treatment and services in connection with any Illness or Injury caused by a Member's: engagement in an illegal occupation; commission of, or an attempt to commit, a felony; or intentional use of illegal drugs.

aa. Reconstructive Surgery/Cosmetic Treatment, except as indicated in this Policy. NOTE: Psychological reasons do not represent a medical or surgical necessity.

bb. Treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, Cosmetic Treatment, or reconstruction when no functional impairment exists, as determined by Physicians Plus.

cc. Injection of filling material such as collagen, salabrasion, rhytidectomy, dermabrasion, chemical peel.

dd. Suction-assisted lipectomy.

ee. Electrolysis.

ff. Mastopexy*.

gg. Augmentation mammoplasty*;

hh. Correction of inverted nipples*;

ii. Reduction mammoplasty (unless You meet the Physicians Plus medical Policy criteria)*;

jj. Sclerosing of spider veins.

kk. Panniculectomy.

ll. Mastectomy for male gynecomastia.

mm. Experimental/Investigational treatments, drugs, devices and/or procedures a Physicians Plus medical director deems Experimental based on Specific Evidence (except HIV-related treatments and drugs authorized by Physicians Plus).

nn. Any treatment, service or supply that is received in a Hospital emergency room (whether received from a Participating Provider or non-Participating Provider) and that does not meet the definition of Emergency Medical Care.

oo. Any services related to the purpose of medical research and/or clinical research trials (except for routine patient care that must be covered under section 632.87(6)(c) of the Wisconsin statutes when administered in a cancer clinical trial).

pp. Acupuncture, hypnotism, goal-oriented behavioral modification, and biofeedback.

- qq. Treatment, services and supplies for holistic or homeopathic medicine, or programs that are not accepted medical practice as determined by Physicians Plus.
- rr. Treatment, services and supplies for, or leading to, sex-transformation surgery and sex hormones related to such treatment.
- ss. Take home drugs and outpatient prescription drugs not specifically covered under this Policy.
- tt. Any service, supply, equipment, medication or other benefit for the treatment of obesity or morbid obesity, including but not limited to gastric and intestinal bypasses, gastric balloons, stomach stapling, wiring of the jaw, liposuction, and weight loss, physical fitness and exercise programs and equipment, even if You have other health conditions that might be helped by the reduction of weight;
- uu. Nutritional supplements and/or vitamins;
- vv. Lodging expenses.
- ww. Transportation expenses (except for covered ambulance transport as outlined in the benefits sections of this Policy).
- xx. Treatment, services and supplies provided by a Member or a Member's Immediate Family or anyone else living with the Member; and/or treatment, services or supplies provided to or received by a Member as a collateral in connection with the treatment of any person who is not a Member under this Certificate.
- yy. Autopsy services.
- zz. Treatment, services and supplies for which the Member has no obligation to pay.
- aaa. Amounts in excess of the Usual and Customary Charge for the covered service, treatment or supply.

* Exclusion does not apply where the Women's Health and Cancer Rights Act of 1988 mandates coverage. See BENEFITS AND SERVICES-SURGICAL SECTION of this Certificate.

14. CLAIMS

PROOF OF CLAIM (POST SERVICE)

A Member must submit written proof of claim to Us within 120 days of occurrence. We must receive:

- a. The completed claim forms if required by Physicians Plus;
- b. The actual itemized bills for treatment or service; and
- c. Any other information that We need to determine Our liability to pay benefits under the Policy.

Circumstances beyond a Member's control might prevent submission of such proof within this time period. So long as the Member files the proof of claim as soon as possible, but no later than one year and 120 days after the occurrence, coverage will not be invalidated unless it was reasonably possible to provide the proof of loss earlier and We have been prejudiced by the delayed proof of loss. In all circumstances Physicians Plus will determine benefits at the time of claim.

CLAIMS PROCEDURES (POST SERVICE)

Benefits payable under the Policy will be paid as soon as reasonably possible after We receive the written proof of claim required to be submitted to Physicians Plus by the Member in accordance with the proof of claim provision. We pay claims in the order they are received up to the limits of the policy. We will decide whether benefits are payable on the expenses for covered services submitted to Physicians Plus within a reasonable period of time after Physicians Plus receives the written proof of claim as described in the proof of claim subsection of this section. Any benefits paid by Us in accordance with the Policy shall fully discharge Us from all further liability to the extent of benefits paid.

If benefits are payable on expenses for services covered under the Policy, Physicians Plus will pay such benefits directly to the Hospital, Physician or other health care Provider providing such services, unless You have already paid the expenses and submitted proof of payment to Physicians Plus before benefits are paid. If You have already paid the expenses and are seeking reimbursement from Physicians Plus, payment of such benefits will be made directly to You.

If there are circumstances that require Physicians Plus to have more time to determine Our liability to pay benefits on a claim, Physicians Plus will send You written notice within 30 days of Our receipt of the proof of claim, explaining why Physicians Plus needs more time to review the expenses. In that case, Our decision on the claim will then be made within 120 days of Our receipt of such proof of claim. An interest payment of 12% per year will be paid on claims not paid within 30 days of Our receipt of all information necessary for claim processing.

If benefits are denied, You will receive a written notice of the denial of such benefit including:

- (A) The specific reasons on which denial or partial denial is based; and
- (B) The specific references to the Policy provisions on which denial or partial denial is based; and
- (C) A description of additional material or information that may be necessary for You to perfect Your claim and an explanation of why such material or information is necessary; and

- (D) An explanation of how You may have the claim reviewed by Physicians Plus if You do not agree with Our denial or partial denial.

15. MEMBER RIGHTS AND RESPONSIBILITIES

Physicians Plus is committed to maintaining a mutually respectful relationship with Members and at the same time we expect Members to assume certain responsibilities. Our members RIGHTS and RESPONSIBILITIES are described below.

You have the right to:

- Receive clear and accurate information about Physicians Plus and Your Policy benefits, Your rights and responsibilities, information about all services offered and how and when You can use such services;
- Receive information (name, address, phone number) about participating Providers, hospitals, pharmacies and other health care Providers available to you;
- Be treated with dignity and respect and to have your personal health information kept private, secure and confidential;
- Participate with physicians and other health care professionals in the decision-making process regarding your health care;
- Candidly discuss appropriate and medically necessary treatment options for your condition(s), regardless of the cost of the benefit and/or coverage;
- Request and receive information about Advance Directives;
- Be informed about preventative health services including self care and how to stay healthy;
- Voice complaints or appeals about Physicians Plus or the care provided to you.

Each Member has the following responsibilities:

- Read and understand materials made available by Physicians Plus concerning your health Plan benefits and coverage. Plan information is available online and/or in the Medical Certificate of Coverage, Schedule of Benefits, Amendments/Riders and Member Handbook;
- Build a relationship with your primary care physician and keep your appointments or provide proper notice if you must cancel with any Provider;
- Provide information that Physicians Plus and Providers need in order to care for you;
- Provide accurate and correct Health Insurance Policy information and arrange to pay for services if you are billed;
- Ask questions about your illness, your treatment Plan and how to manage Your health;
- Follow the plans and instructions for care that you and your physician agree on;
- Treat health Plan and health care Providers, employees and other patients with respect and display proper behavior for the health care setting.

16. APPEALS PROCESS OVERVIEW

The following is an overview of the Physicians Plus Appeal Process, details can be found in the members Medical Certificate of coverage.

COMPLAINT

Situations might occasionally arise when you question or are unhappy with some aspect of the service you received through Physicians Plus. Since most questions about benefits and plan operations can normally be resolved on an informal basis, we encourage you to first try and resolve the problem with the appropriate physician, staff member or by calling our Member Service department at (608) 282-8900 or (800) 545-5015. Your complaint will be documented and investigated. If your complaint is not resolved to your satisfaction, you or an authorized representative may file a grievance with Physicians Plus.

GRIEVANCE

A grievance is any dissatisfaction with services provided by, or claims practices of, Physicians Plus that is expressed in writing to Physicians Plus by or on behalf of you. If you want to submit a grievance, please submit it in writing, along with any pertinent documentation, to:

Physicians Plus Insurance Corporation

Appeal Administrator
22 East Mifflin Street, Suite 200
PO Box 2078
Madison, WI 53701-2078

You (or your authorized representative) will have the right to participate in the Grievance Committee meeting in person or by teleconference to present written and/or oral information. If you choose to participate (or have your authorized representative participate) in the Grievance Committee meeting, you must notify Physicians Plus no less than four business days prior to the date of the hearing.

If a person is acting as your authorized representative in the grievance process, Physicians Plus may require written evidence of the representative's authority to act on your behalf.

EXPEDITED GRIEVANCE

If your grievance or complaint is regarding a situation where if delayed the delay might seriously jeopardize the life or health of our member, our review will be expedited as medically indicated and take no more than 72 hours from the time received to render a decision. The Grievance Committee may not formally meet to review expedited grievances.

INDEPENDENT REVIEW PROCESS

You may be entitled to an independent review of a final adverse determination involving care that has been determined not to meet Physicians Plus requirements for medical indicated, appropriateness, health care setting, level of care, effectiveness of care received or experimental treatment or services.

Please contact the Physicians Plus Grievance Administrator within 120 days (4 months) after receiving a notice of a grievance denial at (608) 282-8900 or (800) 545-5015, for information regarding filing fees, and the process of initiating this type of review.

OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

You may resolve your concern by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance (OCI), a state agency that enforces Wisconsin's insurance laws, and file a complaint. You may contact OCI by writing to:

Office of the Commissioner of Insurance
Complaints Department
125 South Webster Street
PO Box 7873
Madison, WI 53707-7873

You may call (608) 266-0103 in Madison or (800) 236-8517 outside of Madison to request a complaint form, or go to the OCI website at www.oci.wi.gov

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

You also may have a right to bring a civil action under ERISA 502(a) if you file an appeal and your request for coverage or benefits is denied following review. ERISA has established timelines that limit filing an appeal. Appeals must be filed no more than 180 days from the date of the initial denial. Please contact your employer for more information on your rights under ERISA (ERISA does not apply to State, ETF or Non-Group plans including Medicare Supplement).

17. SUBROGATION/WORKERS COMPENSATION

For subrogation, Physicians Plus business partner Ingenix will pend all claims with a diagnosis common to accident or work-related conditions. Ingenix will then contact the member either by telephone or mail to request information to facilitate subrogation against the responsible party.

Upon request, Ingenix will provide the employer group with an annual report, which breaks down the financial recoveries for subrogation efforts. Work-related claims are an exclusion; employees should refer to their medical certificate for more details.

SUBROGATION

Physicians Plus does not duplicate benefits when another party is financially responsible for an injury or illness (e.g., an auto accident, or accident on another person's private property). Physicians Plus retains the right to recover (subrogate) costs for services rendered when another party may be liable for payment of medical expenses. Please call your Group Service Representative if you become aware of situations in which another party is financially responsible for an injured employee.

WORKER'S COMPENSATION

Physicians Plus does not cover injuries or illnesses covered by Worker's Compensation. The employer's Worker's Compensation carrier should be billed for these charges. However, if benefits are paid by Physicians Plus and it is determined that a member is eligible to receive worker's compensation for the same incident, Physicians Plus has the right to recover any benefits provided.

Please see the Medical Certificate of Coverage for detailed information on Subrogation and Workers Compensation.

18. TERMINATION OF COVERAGE

Coverage under this Policy ends on the earliest of the following dates except as described in EXTENSION OF BENEFITS section of this Certificate:

- (A) The date the Policy terminates;
- (B) The date the Member dies;
- (C) The date the Member meets the lifetime benefit maximum for this Policy;
- (D) The last day of the calendar month for which the Member's premium contribution, if any, has been paid;
- (E) The date a Member enters into military service, other than for duty of less than 30 days;
- (F) If You're absent from work due to an Injury or Illness, the last day of the calendar month in which Your status as an employee ends as determined by his/her employer;
- (G) For an employee, the last day of the calendar month in which You aren't within the class of employees eligible for coverage under the Policy;
- (H) For an employee's spouse and/or other dependent who is a Member, the date the employee's coverage terminates;
- (I) For the employee's spouse, the date Your employee's spouse is no longer married to You due to divorce or annulment;
- (J) For the employee's Eligible Dependent child, stepchild, adopted child, or child Placed for Adoption with the employees to be eligible, the earliest of the following dates:
 - (1) The date the child marries;
 - (2) The date the child acquires or is eligible for other coverage under his/her own Policy;
 - (3) The date the Member or child meets the lifetime benefit maximum for this Policy;
 - (4) The last day of the calendar month when the child exceeds the Maximum Dependent age (19 or, so long as the dependent is a Full Time Student, 25). However, a child, who otherwise satisfies the coverage requirements and is permanently and Totally Disabled, may remain eligible under Family Coverage beyond the Maximum Dependent age. Physicians Plus will work with the employee, the dependent child and the Attending Physician to establish the child's mental or physical disability. Physicians Plus will make the final decision regarding eligibility of a disabled child. Eligibility will be verified annually;
- (L) For the grandchild of the covered employee the date that the grandchild's parent reaches age 18 or otherwise loses coverage;
- (M) The date a Member is disenrolled as described in any section of this Policy; and
- (N) For a child that is Placed(Placement) for Adoption with the employee but for whom the adoption is not finalized, the date when the child's adoptive placement with the Subscriber is terminated.

DISENROLLMENT PROVISION

We may terminate a Member's coverage and disenroll such Member from Physicians Plus coverage for any of the following reasons:

- (A) The Member has failed to pay required premium by the end of the grace period;
- (B) The Member has reached the Policy lifetime limits;
- (C) The Member has committed acts of physical or verbal abuse that pose a threat to Providers or other Physicians Plus Members;
- (D) The Member has improperly allowed a person other than a Member to use a Physicians Plus identification card to obtain services or has knowingly provided fraudulent information in applying for coverage;
- (E) The Member is unable to establish or maintain a satisfactory physician-patient relationship with the Member's PCP; or

- (F) Physicians Plus has not renewed the Policy; or
- (G) The Member establishes residence outside of the Service Area.

Disenrollment for reason (E) shall occur only after We have provided the Member with the opportunity to select an alternate PCP, made a reasonable effort to assist the Member in establishing a satisfactory physician-patient relationship and told the Member that a Grievance may be filed on this matter. If a Member is disenrolled for reasons (C), (D), (E) coverage shall continue until the Member finds other coverage or until the next opportunity for the Member to change insurers, whichever comes first.

Certificate of Creditable Coverage

When a member's coverage is terminated, a certificate of creditable coverage is generated and mailed to the member at their home address. This form documents the member's enrollment in the group health plan. Members may need this certificate to present to their new insurance carrier. Any member needing a certificate of creditable coverage may request one through by calling our Member Service department at (608) 282-8900 ext 3517 or 1-800-545-5015 ext 3517.

19. CONTINUATION & CONVERSION

Continuation administration is the responsibility of the Employer Group. Continuation coverage does not apply to individual coverage or coverage NOT provided by an employer. Please terminate a member as soon as possible after such an event. If the member is eligible for continuation coverage we can add the member after the required notices are sent.

WISCONSIN CONTINUATION

In certain cases a Member may be eligible to continue terminated coverage that would otherwise end under general provisions. Those eligible for continuation of coverage are:

- (A) A Subscriber who is no longer eligible under the Policy, except if employment is terminated for misconduct on the job; or
- (B) A Subscriber's spouse or dependent who is no longer eligible under the Policy due to divorce, annulment or death of the Subscriber.

In either case, the Member must have been covered under the Policy for at least three months prior to the termination date of coverage.

Within five days of receiving notice to end a Member's coverage, the Policyholder must notify the Member of:

- (A) The option to continue coverage under this provision or convert coverage as provided under conversion Policy provisions;
- (B) The premium amount the Member must pay monthly to continue coverage or purchase the conversion Policy;
- (C) The manner in which and the place to which the Member must make premium payments; and
- (D) The time by which the Member must pay for continuation of coverage.

Continuation of coverage under the Policy may be continued until the earliest of the following dates:

- (A) The date the Member becomes eligible for other similar group coverage;
- (B) For a Member spouse who originally obtained coverage through his/her former spouse, the date his/her former spouse is no longer eligible for coverage under the Policy;
- (C) The date the Policy terminates;
- (D) The date the Member moves out of Wisconsin;
- (E) The end of the period of time for which the Member timely paid premium; or
- (F) The end of 18 months after the Member elects continuation of coverage.

A Member may convert to an individual medical expense conversion Policy when continuation of coverage ends unless continuation of coverage ends because of nonpayment of premium to Us as required (see conversion Policy provision).

FEDERAL CONTINUATION or COBRA

COBRA

A Member who is no longer eligible for coverage under the Policy, such as former employees, certain dependent children and divorced or surviving spouses and their dependent children may be eligible for continuation of coverage in accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended. To the extent COBRA applies to a Policyholder or Member, the following provisions apply:

COBRA requires a Member to notify the Policyholder of a divorce or legal separation, the date on which a child ceases to be an Eligible Dependent, that would cause a loss of coverage and within 60 days of such event. The Policyholder then has 14 days to notify the Member of the right to elect coverage under COBRA.

The Policyholder must notify Physicians Plus within 30 days of a Subscriber's death, termination, reduction in hours of employment, entitlement to Medicare or the Policyholder's initiation of bankruptcy proceedings.

Failure to comply with any of these required notice periods may result in a Member's ineligibility for COBRA coverage.

COBRA coverage is available for limited periods of time, which vary according to the Member's status and the particular circumstances that resulted in loss of eligibility for coverage. Despite these time limits, COBRA coverage will cease when:

- (A) The Member becomes covered under any other group Plan that has no exclusion for Pre- Existing conditions of the Member; or
- (B) The Member becomes entitled to Medicare (in most instances);
- (C) Premiums are no paid on a timely basis; or
- (D) The Policyholder ceases to maintain any group health Plan.

The Member is required to notify the Policyholder if either event (A) or (B) occurs while the Member has COBRA coverage.

USERRA

The federal Uniformed Services Employment and Reemployment Rights Act, as amended (USERRA), also grants continuation rights to employees who leave their employment to perform military service. Those Members may be eligible to elect to continue their group coverage for themselves and their dependents for up to 24 months.

If properly elected, the USERRA continuation coverage begins on the date when the employee's absence from work for the purpose of performing military service begins. If the Member performs military service for fewer than 31 days, he/she cannot be required to pay more than the regular employee share, if any, for the group coverage. If the Member performs military service for 31 or more days, he/she can be required to pay no more than 102% of the full premium under the Plan.

If You will be leaving Your employment in order to perform military service, please see Your employer for information on electing to continue Your group health coverage.

COBRA/Wisconsin Continuation Chart

If both COBRA and Wisconsin Continuation apply, use the law most favorable to the insured.

	COBRA	Wisconsin Continuation Law
Which law applies to my company?	This law applies to employer's insurance policies purchased for insured or self-insured group plans, for companies with 20 or more employees. (COBRA does not apply to federal government and church plans.)	The law regulates the group health insurance policies purchased for all insured group plans, regardless of size, which operate in the state of WI.
Who does continuation apply to?	Any "qualified beneficiary" who on the day before a "qualifying event" is covered under the group plan and who would lose coverage under the group plan as a result of the qualifying event.	Any of the following persons who have been continuously covered under a group policy for at least 3 months: <ol style="list-style-type: none">1) The former spouse of a covered employee who would lose coverage upon divorce or annulment;2) The spouse or dependent of the covered employee upon employee's death (if the spouse/dependent also was covered);3) The covered employee, his or her covered spouse and any covered dependents upon termination of the employee's eligibility, such as termination of employment (unless discharged for "misconduct").

When do I notify?	<p>Upon initial enrollment, each covered employee and his/her spouse must be provided written notice of their continuation rights as provided by COBRA.</p> <p>Upon receiving notification of the occurrence of a qualifying event, the plan administrator (often the employer) must notify qualified beneficiaries of their COBRA election rights within 14 days.</p>	Upon receiving notification to terminate coverage, the employer must provide written notice within 5 days.
	COBRA	Wisconsin Continuation Law
How do I know there has been a qualifying event?	<p>The employee/qualified beneficiary is responsible for notifying the plan administrator of a qualifying event within 60 days of the following events:</p> <ul style="list-style-type: none"> • Divorce or legal separation of a covered employee, or • A dependent child ceasing to be a dependent under the plan. • <p>The employer generally must notify the plan administrator of a qualifying event within 30 days of the following events:</p> <ul style="list-style-type: none"> • Death of the covered employee, • Termination or reduction of hours of the covered employee, • The covered employee becoming entitled to Medicare, or • The bankruptcy of the employer. <p>(However, you are not required to wait until formal notice of a qualifying event is received to send an election notice.)</p>	When the employer is notified to terminate coverage (for example, upon divorce or annulment) or learns of an event resulting in a loss of coverage (for example, termination of the employee's employment or the employee's death), the employer's duty to provide the notification of election rights is triggered.

<p>When does the election period begin and end?</p>	<p>The election period generally begins on the date of the qualifying event, and ends 60 days after the later of the date of (1) loss of coverage and (2) the date the qualified beneficiary receives notification from the plan administrator.</p>	<p>The election period commences on the date the insured receives notification from the employer and ends 30 days after.</p>
<p>When does continuation coverage begin?</p>	<p>Continuation coverage generally begins on the date of the qualifying event.</p>	<p>At the time coverage would otherwise terminate, coverage continues without interruption, provided the group policy member elects continuation coverage under group policy or conversion to individual coverage and timely pays the required premium.</p>
	<p>COBRA</p>	<p>Wisconsin Continuation Law</p>
<p>When does continuation coverage end?</p>	<p>Continuation coverage ends upon the occurrence of specified events, as follows:</p> <ul style="list-style-type: none"> a. The employer no longer provides group coverage to any employee. b. The insured fails to make timely premium payment. c. The insured becomes covered by another group policy, unless there is a pre-existing clause on the new group plan, after being enrolled under COBRA. d. The insured becomes entitled to Medicare, after being enrolled under COBRA. e. The “maximum required period” ends. The maximum required period generally is 18 months from the date of the covered employee’s termination or reduction of hours or 36 months from the date of other qualifying events. 	<p>Continuation coverage terminates only upon the occurrence of one of the following:¹</p> <ul style="list-style-type: none"> a. The insured establishes residence outside Wisconsin. b. The insured fails to make timely premium payments. c. The insured becomes eligible for another group policy, unless the plan has a pre-existing condition limitation or exclusion. d. When the covered employee ceases to be eligible for coverage, coverage of a former spouse also ends. e. The end of 18 months of continuation coverage, if the insurer requires conversion to individual coverage at any time beginning after 18 months of continuation coverage.

What premiums do I charge?	The premium for any period of continuation coverage may not exceed 102% of the cost to the group plan. ²	The premium for any period of continuation coverage may not exceed the group rate in effect (including the employer's contribution) for a covered employee.
When are premiums paid?	Coverage under the group plan continues uninterrupted if an appropriate election is made and the premium is tendered within 45 days of the election. A grace period of 30 days applies to all subsequent premium payments.	Continuation or conversion coverage, as applicable, continues uninterrupted if an appropriate election is made and the premium is tendered within 30 days after receipt of notification from an employer. There is no grace period for subsequent premium payments.

IN-AREA CONVERSION POLICY PROVISION

After coverage ends as described in when coverage ends provision, or at the end of Wisconsin or COBRA continuation of coverage as described in continuation of coverage, a Member may be eligible to purchase the type of individual medical expense conversion Policy that Physicians Plus makes available to eligible Members.

To obtain the conversion Policy, the Member must be eligible, as determined by Physicians Plus, apply to Physicians Plus and pay the required premiums to Physicians Plus. The Member must do this within 30 days to the Policy holder notifying the Member of his/her right to conversion coverage. If the Member applies and pays within the 30-day period, the conversion Policy will cover the Member as of the date coverage under the group Policy ends.

To obtain information on the plans offered by Physicians Plus please contact Our Member Service department at (608) 282-8900 or (800) 545-5015.

20. MEDICARE & RETIREES

The following general information is being provided as a guide to Medicare and Retirees.

Members can become eligible for Medicare for various reasons which include age, disability or illness, such as end stage renal disease (ESRD). Medicare determines eligible for Medicare. Medicare has 3 parts or types of coverage:

1. Medicare A – Inpatient hospital services
2. Medicare B – Outpatient physician services
3. Medicare D – Prescription drug coverage

Physicians Plus cannot force any member to enroll in any part of Medicare; however Medicare may assess a penalty in some instances for late entry. If a member has questions about their Medicare eligibility they must contact Medicare direct.

Many employers offer coverage for employees that retire or wish to retire before and/or after Medicare eligibility. Physicians Plus must approve a retiree segment if you intend to offer health insurance to those retirees. The following minimums must be in place before Physicians Plus will approve a retiree division:

- Retiree is no longer working;
- No more than 10% of the population can be retirees;
- Contribution is equal to or exceeds 50% of the single rate;
- Minimum age is 55;
- Maximum age is 65.

Coordinating benefits with Medicare is an essential piece for retiree coverage. Please consider the following tables and coordination of benefit rules when considering retiree coverage for your employees.

EMPLOYEE IS ACTIVE AT WORK

Medicare Eligibility Summary for an EMPLOYEE who is CURRENTLY WORKING			
Number of total Employees	Enrollment in Medicare A & B	PRIMARY CARRIER	SECONDARY CARRIER
2-19	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
2-19 & Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
20-99	Not Mandatory. May defer for employee and/or dependents.	Physicians Plus	Medicare
20-99 Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus

100 or More	Not Mandatory. May defer for employee and/or dependents regardless of age or Medicare disability.	Physicians Plus	Medicare
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EMPLOYEE IS NOT WORKING

Medicare Eligibility Summary for an EMPLOYEE who is NOT CURRENTLY WORKING (Retired, on Long Term Disability or Continuation).			
Number of total Employees	Enrollment in Medicare A & B	PRIMARY CARRIER	SECONDARY CARRIER
2-19	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
2-19 & Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
20-99	Not Mandatory. May defer for employee and/or dependents.	Medicare	Physicians Plus
20-99 Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
100 or More	Not Mandatory. May defer for employee and/or dependents regardless of age or Medicare disability.	Medicare	Physicians Plus

NOTE: Group size is determined by the average number of total employees on the payroll record for the prior IRS calendar year. If more than one business is commonly owned, all owned entities combined.

This guideline does not reflect all the possible criteria affecting the primary payer rules. For details please contact the social security administration.

21. OTHER - NOTES