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# MEDICARE SUPPLEMENT INSURANCE

## HMO MEDICARE SELECT POLICY

Medical Certificate of Coverage

Healthy *Choices.*  
Big *Rewards.*

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# TABLE OF CONTENTS

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1. ABOUT THE POLICY	1
2. WELCOME TO PHYSICIANS PLUS	2
3. EMERGENCY AND IMMEDIATE/URGENT MEDIAL CARE	3
4. IMPORTANT PHONE NUMBERS AND ADDRESSES	5
5. BENEFITS AND SERVICES	6
6. GENERAL EXCLUSIONS	10
7. POLICY TERMINATION, GUARANTEE ISSUES AND SUSPENSION	12
8. PAYMENT OF CLAIMS	14
9. APPEAL PROCESS	15
10. GENERAL CONDITIONS	19
11. DEFINITIONS	23

# 1. ABOUT THE POLICY

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## HMO MEDICARE SUPPLEMENT INSURANCE POLICY

### PHYSICIANS PLUS INSURANCE CORPORATION MEDICARE SUPPLEMENT POLICY

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets those standards. It, along with Medicare, may not cover all of your medical costs. You should review all policy benefits, exclusions and limitations carefully. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare", given to you when you applied for this policy. Do not buy this policy if you did not receive this guide.

### YOUR RIGHT TO RETURN THIS POLICY

Please read this policy right away. If you're not satisfied with it for any reason, you can return it within 30-days. Upon return, this policy becomes invalid. Physicians Plus will refund all payments you've made on it. Upon your payment of premium and the issue of this policy and an identification (I.D.) card, Physicians Plus agrees to provide the benefits described in this policy.

### IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read a copy of your application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the insurer within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

### GUARANTEED RENEWABLE FOR LIFE - PREMIUM SUBJECT TO CHANGE

You must have Medicare Part A and B to qualify for this policy. Physicians Plus will renew this policy for as long as; you pay the premium due on time; you have Medicare part A & B; and you live in the Physicians Plus Service Area (Dane, Columbia, Dodge, Grant, Green, Iowa, Jefferson, Juneau, Lafayette, Richland, Rock, Sauk and Vernon). You cannot be cancelled because you have used or overused benefits. Physicians Plus Insurance Corporation can raise your premium only if Physicians Plus raises the premium for all policies like yours. Your premium will also change at the next renewal date (January 1<sup>st</sup>) after you attain the following ages: 65, 70, 75, 80 and 85. Your premium will not increase on the basis of age after age 85.

This policy is in force for the initial period of coverage through December of that calendar year. This is true if we have accepted a timely prepaid premium. After that, Physicians Plus will renew this policy for further periods of coverage if you pay your premiums on time.

### YOUR RIGHT TO CANCEL THIS POLICY MIDTERM

This policy provides for midterm cancellation at the request of the member or authorized representative. If the member cancels a policy midterm or the policy terminates midterm because of the member's death, Physicians Plus will issue a prorated refund to the member or the member's estate.

### USUAL AND CUSTOMARY

This is an HMO Medicare Select Supplement policy; this policy requires you to seek services from a Physicians Plus Insurance Corporation participating provider. If services are provided by a non-participating provider usual and customary limits may apply to claims payment. Usual and Customary means the usual and customary amount payable based upon the average charge for the same service provided by other providers of a similar type, training, and experience, in the same or similar geographical area and should not exceed the fees that the provider would charge any other pay or for the same services. Other factors such as, but not limited to, complexity, degree of skill or type of provider may also determine a usual and customary fee. Usual and Customary fees apply to Wisconsin mandated benefits only.

## **2. WELCOME TO PHYSICIANS PLUS INSURANCE CORPORATION**

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It is Your responsibility to know Your benefits. Please carefully read the information provided in this Medical Certificate, Schedule of Benefits and any riders and/or amendments that may apply to Your Plan. This is the Medical Certificate used by Physicians Plus to administer benefits and process claims.

Please ALWAYS keep these KEY POINTS in mind:

1. **This is an HMO Policy. YOU MUST SEEK SERVICES WITH A PARTICIPATING PROVIDER.**

Some Providers may practice at more than one clinic. Please refer to the index of the Provider Directory for a listing of participating Providers and locations. Providers are only covered at the locations listed in the Provider Directory. Our Provider Directory is available on our website at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com)

2. **Always consult with Your Primary Care Physician (PCP)** for all Your primary and specialty care needs.

3. If You are seeing a Provider other than Your PCP, prior authorization may be required. **Please talk with Your PCP to obtain prior authorization when needed.**

4. **You may change Your PCP** at any time by calling Our Member Service department at (608) 282-8900 or (800) 545-5015 or visit Our website at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com). The change will be effective on the first of the month following Our notification of the change.

5. **ALL inpatient care including hospitalizations, hospital rehabilitation, hospice care and skilled nursing facilities require PRIOR AUTHORIZATION before services are provided.** If You do not obtain Prior Authorization when required, services will not be covered. Please contact Our Member Service department if You have questions regarding Our Prior Authorization requirements.

**Meriter Hospital and the University of Wisconsin Hospitals and Clinics (UWHC) are the participating hospitals in the Madison area.**

**Planned hospital admissions at non-participating Hospitals WILL NOT be authorized.** Non-participating 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.

6. **If You have questions about Your Policy or coverage please contact Our Member Service department** at (608) 282-8900 or (800) 545-5015 or visit Our website at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com).

7. **PLEASE IMMEDIATELY READ THE EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE SECTION OF THIS CERTIFICATE.**

### **3. EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE**

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EMERGENCY and IMMEDIATE/URGENT MEDICAL CARE in and out of the Physicians Plus Service Area

Emergency Medical Care means Medical Services provided to a Member by a Physician or other medical professional licensed by the state in which the care is provided in connection with an Emergency Medical Condition.

As defined by Wisconsin Statute 632.85 "Emergency Medical Condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- (1) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- (2) Serious impairment to the person's bodily functions; or
- (3) Serious dysfunction of one or more of the person's body organs or parts.

Emergency Medical Care does not include routine health, dental or maintenance treatment, services and supplies and/or routine medical exams.

Meriter Hospital and the University of Wisconsin Hospital and Clinics are the Participating Hospitals in the Madison area. Meriter Hospital is the preferred Participating Hospital in the Madison Area. St. Mary's Hospital Madison is NOT a Participating Hospital in the Madison area. Please see Your Provider Directory for a complete list of Participating Hospitals in Your area.

Treatment and services provided in any Hospital emergency room must meet the definition of "Emergency Medical Condition"(see definition above). If services are provided in a Hospital emergency room that do not meet the definition of Emergency Medical Care, coverage for the services will be denied and You will be responsible for the payment of all charges. All benefits are determined at the time of claim.

If You require Emergency Medical Care and You are in the Physicians Plus Service Area, You should go to a Participating Hospital emergency room for services when You can safely do so. If You cannot safely travel to a Participating Hospital and there is a closer Non-Participating Hospital, You should go to that closer Hospital emergency room for assistance and notify Physicians Plus within 48 hours or as soon as medically possible. If You are admitted to either a participating Hospital or Non-Participating Hospital, You and/or the Hospital must notify Physicians Plus within 48 hours of the admission or as soon as medically possible.

If You are out of the Physicians Plus Service Area and require Emergency Medical Care and cannot safely return to the Service Area to receive that care, You should go to the closest Hospital emergency room and notify Physicians Plus within 48 hours or as soon as medically possible. If You are admitted to the Non-Participating Hospital, You and/or the Hospital must notify Us within 48 hours or as soon as medically possible.

Once You are stable, Physicians Plus will seek to have You transferred to a Participating Hospital in Our Service Area. If You are not transferred to a Participating Hospital, Physicians Plus will coordinate Your care with the Hospital and Physicians.

Physicians Plus does not have contracts with out of network providers and therefore has no control over costs, billing and/or coding practices and/or the quality of treatments, services and supplies provided by a out of network provider.

All Physicians Plus polices include an emergency room Copayment and/or Deductible and Coinsurance. Please read Your Schedule of Benefits carefully to determine the applicable Copayment and/or Deductible and/or Coinsurance that may apply. Deductibles, Coinsurance, Copayments and maximums on any Physicians Plus Policy are cost sharing mechanisms. Cost sharing mechanisms are not penalties for obtaining services.

Physicians Plus will waive the emergency room (ER) copayment ONLY when the patient is admitted to the Hospital within 24 hours for the same Illness or Injury treated in the emergency room. In some cases, a patient may be in an observation bed. This is NOT an admission and is not billed as an Inpatient Admission and/or stay. Observation is normally billed by the Hospital as an ER visit. If so, the Copayment is not waived.

Immediate/Urgent Medical Care: If You require Immediate/Urgent Medical care and are not able to wait until You can see Your PCP You should:

- (1) CONTACT YOUR PCP: Your PCP will direct You to the most appropriate immediate care facility available; or
- (2) CONTACT NursePlus at (866) 775-8776 or (866) PPLUSRN; or
- (3) SEEK IMMEDIATE/URGENT CARE: Go to a Immediate/Urgent Medical Care center that is a Participating Provider.

If You are out of the Service Area and require Immediate/Urgent medical care services, follow the instructions 1-2 above. If You are instructed by Your PCP or the NursePlus line to seek services from a Non-Participating facility for Immediate/Urgent or Emergency Care, please contact Physicians Plus within 48 hours to report that You received services from a Non-Participating Provider. Physicians Plus will determine benefits at the time of claim.

Non-Emergency and Non-Immediate/Urgent Care While Out of the Service Area: Any medical care when You are out of the Service Area must be Prior Authorized except for (a) Emergency Medical Care (b) Immediate/Urgent Medical Care and (c) those services for an Eligible Dependent Student described immediately below.

Any medical care that can be safely postponed until you return to the Service Area will not be Prior Authorized for coverage out of the service area. If follow up care is Prior Authorized and Medically Indicated, We will cover 50% of follow up care up to the Usual and Customary Charge for covered treatment, services or supplies. Physicians Plus will determine benefits, including whether the medical care is Medically Indicated, at the time a claim is made.

Outpatient Behavioral Health and chemical dependency services for Eligible Dependent students out of the Service Area: Physicians Plus will cover services for Prior Authorized Outpatient Behavioral Health and AODA services out of the Service Area for a dependent, if the dependent is a qualified full-time student attending school and living in Wisconsin but out of the Physicians Plus Service Area.

- The qualified dependent may have a clinical assessment by a Non-Participating Provider that Physicians Plus designates. If outpatient services are Medically Indicated, Physicians Plus will cover 5 outpatient visits. All visits must be Prior Authorized by Physicians Plus.
- If the dependent is unable to maintain full-time student status, the dependent must return to the Physicians Plus Service Area for treatment with a Participating Provider.
- Physicians Plus will determine benefits at the time of claim.

Physicians Plus will not cover any treatment, services or supplies received that are not Medically Indicated as determined by Physicians Plus; or that are not authorized by Physicians Plus. Any follow-up care received at a Non-Participating Hospital or Physician after the emergency service is not a covered benefit, unless Prior Authorized by Physicians Plus.

## 4. IMPORTANT PHONE NUMBERS AND ADDRESSES

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### Physicians Plus Insurance Corporation

WEB SITE: [www.pplusic.com](http://www.pplusic.com)

## GO-TO

Access your healthcare information, claims and authorizations, change your PCP and more with GO-TO our 24/7, free, secure, and easy to use online resource. GO-TO our Web site at [www.pplusic.com](http://www.pplusic.com) for more GO-TO information



### HEALTH CARE ADVICE ANYTIME !

Physicians Plus NursePlus Nurse Line  
Available 24/7 call one of the nurses toll free  
at 866-PPLUSRN or (866) 775-8776

### Member Services

Phone: (608) 282-8900 or (800) 545-5015  
TDD: (608) 260-7998  
Fax: (608) 258-1902  
E-Mail: [ppicinfo@pplusic.com](mailto:ppicinfo@pplusic.com)

### Medical Claims

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

### Chiropractic Claims

ChiroTech America, Inc.  
N14 W23833 Stone Ridge Drive Suite 330  
Waukesha, WI 53188

**Behavioral Health and/or Alcohol or Drug Abuse:** For Prior Authorization please contact  
UW Behavioral Health Case Management and Consultation Services at:  
Phone: (608) 282-8960 or (800) 683-2300

## **5. BENEFITS AND SERVICES**

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You must live in the Physicians Plus service area (Dane, Columbia, Dodge, Grant, Green, Iowa, Jefferson, Juneau, Lafayette, Richland, Rock, Sauk and Vernon) and have Medicare Parts A and B to be eligible for this policy. This policy will **supplement** benefits for Medicare eligible expenses under Medicare parts A and B. Benefits not covered by Medicare will not be covered by this policy except those listed in this policy and the appropriate Schedule of Benefits.

### **1. Inpatient Hospital Services, Kidney Disease Services**

#### **A. INPATIENT HOSPITAL SERVICE**

Subject to the terms of this policy, Physicians Plus will pay the following benefits for Medicare eligible expenses that are considered Medically Necessary Hospital Services under Medicare Part A and if you are admitted as an Inpatient during any Benefit Period that starts on or after your Effective Date and while this Policy remains in effect.

1. The Medicare Deductible during the period Medicare provides benefits.
2. The Medicare Coinsurance during the period Medicare provides benefits.
3. After you have used up your Medicare Hospital days and lifetime reserve days (150 days) during a benefit period, Physicians Plus will pay medically necessary inpatient hospital service charges during that benefit period, up to the limits of the policy.
4. If you are Inpatient in a psychiatric hospital, and you use up all your Medicare hospital days, Physicians Plus will pay charges for medically necessary inpatient hospital service for up to 175 more days during your lifetime.
5. Physicians Plus will pay charges for your Medicare Part A blood deductible if the blood is not replaced on your behalf.

#### **B. KIDNEY DISEASE SERVICES**

Subject to the terms of this policy, Physicians Plus will pay charges for the following services you receive on or after your effective date and while your policy remains in effect, provided they are medically necessary.

1. Inpatient Hospital Service;
2. Kidney dialysis;
3. Kidney transplant, including the donor's expenses.

The maximum amount that Physicians Plus will pay for this treatment is \$30,000 in a calendar year. Physicians Plus payment will not duplicate any Medicare payments for kidney disease treatment.

### **2. Skilled Nursing Care**

Subject to the terms of this policy, Physicians Plus will cover medically necessary skilled nursing care. The extent of benefits Physicians Plus will pay depends in part on whether or not your care is medically necessary and qualifies for Medicare coverage.

#### **A. SKILLED NURSING CARE THAT QUALIFIES FOR MEDICARE COVERAGE**

Physicians Plus will pay the Medicare coinsurance amount for the skilled nursing Medicare eligible expenses incurred per benefit period in which you are confined to a skilled nursing facility up to the limits of your policy, see Schedule of Benefits. Once Medicare stops paying benefits identified in this section, you may be eligible for the benefit listed in section B below.

## **B. SKILLED NURSING CARE THAT DOES NOT QUALIFY FOR MEDICARE COVERAGE**

If your stay in the skilled nursing facility does not qualify for coverage under section A above (i.e., the skilled nursing facility is not Medicare approved and/or the stay does not meet Medicare's definition of skilled care) or if your benefits are exhausted under Section A above, Physicians Plus will pay skilled nursing facility charges up to 30 days per benefit period. You must meet the following conditions:

1. You are confined to a licensed Skilled Nursing Facility;
2. Your Physician certifies that Skilled Nursing Care is Medically Necessary at the time You are admitted and every 7 days thereafter; and
3. Physicians Plus must determine that you are receiving Medically Necessary Skilled Nursing Care.

Our payment will equal the maximum daily rate set for the Skilled Nursing Facility by The Wisconsin Department of Health and Family Services.

## **3. Home Care**

Subject to the terms of this policy, Physicians Plus will pay charges for medically necessary home care that you receive under the plan of care established, approved in writing, and reviewed at least every 2 months by your physician. Your condition must be such that, without the home care, you would be confined to a hospital or to a skilled-care bed in a skilled nursing facility.

Each consecutive 4 hours in a 24-hour period of home health aide services is considered one home care visit.

### **A. HOME CARE SERVICES INCLUDE:**

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse.
2. Part-time or intermittent home health aide services which:
  - a. are medically necessary as part of the home care plan;
  - b. are under the supervision of a registered nurse or medical social worker;
  - c. are required to be performed by a registered nurse or licensed practical nurse; and
  - d. do not consist solely for caring and aiding in performing normal activities of daily living.
3. Physical or occupational therapy, or speech/language pathology or respiratory care.
4. Laboratory services, medical supplies, drugs and medications prescribed by your physician, to the extent the services or items are necessary under your home care plan.
5. Nutrition counseling provided by or under the supervision of a registered dietician or dietician certified under subchapter V of chapter 448 of the Wisconsin Statutes where such services are medically necessary as part of the home care plan.
6. The evaluation of the need for the development of a home care plan by a registered nurse, physician extender or medical social worker, when approved or requested by your physician.

### **B. HOME CARE CONDITIONS**

1. Your physician must certify that:
  - a. You would have to be confined to a hospital or skilled nursing facility if you did not receive home care;
  - b. Medically necessary care and treatment are not available from your immediate family or other persons living with you without causing undue hardship;
  - c. Your home care is provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency;

- d. If you were in a hospital immediately before the start of home care, the physician who attended you in the hospital must approve the home care plan.

### **C. HOME CARE LIMITATIONS**

1. Physicians Plus will pay for 365 home care visits per calendar year.
2. The maximum weekly benefit for home care will not be more than the usual and customary weekly cost of care in a skilled nursing facility.

### **D. HOME CARE EXCLUSIONS**

Home care services do not include:

1. Services or supplies that would not be covered if you were confined in a hospital or skilled nursing facility.
2. Custodial Care.
3. Services or supplies not medically necessary.
4. Preparation of food, housing, homemaker services, or home-delivered meals.
5. Services or supplies not included in your home care plan.
6. Services provided by members of your immediate family, or by persons living with you.

## **4. Medicare Part B Expenses & Other Covered Services**

This policy will supplement benefits for Medicare eligible expenses under Medicare Parts A and B. Benefits not covered by Medicare will not be covered by this policy except those listed in the appropriate Schedule of Benefits.

Subject to the terms of this policy, Physicians Plus will pay the following benefits for Medicare eligible expenses that are considered medically necessary under Medicare Part B, on or after your effective date and while this policy remains in effect.

### **A. MEDICARE PART B EXPENSES**

1. The Medicare Deductible during the period Medicare provides benefits;
2. Physicians Plus will pay the Medicare Part B coinsurance amounts for Medicare eligible expenses covered under Medicare Part B, provided those Medicare eligible expenses were incurred on or after the effective date of this policy.

### **B. OTHER COVERED SERVICES**

Physicians Plus will pay charges for the following medically necessary medical services and/or supplies if they are not considered Medicare eligible expenses and were incurred on or after the effective date of this policy:

1. Routine care not covered by Medicare: This policy will cover preventive health care services not covered by Medicare. Services must be medically appropriate as determined by an attending physician. This policy will reimburse charges up to 100% of the Medicare approved amount for each service up to \$120 annually.
2. Hospital or ambulatory surgery center charges and anesthetics provided for dental care for a covered individual if he or she meets any of the following conditions.
  - a. the individual is under the age of 5;
  - b. the individual has a chronic disability that is attributable to a mental and/or physical impairment which results in substantial functional limitation in an area of the individual's major life activity, and the disability is likely to continue indefinitely; or
  - c. the individual has a medical condition that requires hospitalization or general anesthesia for dental care.

3. The Woman's Health and Cancer Rights Act (WHCRA) of 1998: Mandates the following benefits if you are receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, coverage for (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; (3) prostheses and physical complication all stages of mastectomy, including lymphedemas.
4. Diabetic equipment and supplies covered under Medicare Part B, including:
  - a. Syringes, specimen tape and other supplies used to treat diabetes;
  - b. An insulin infusion pump. Physicians Plus will pay for one pump in a calendar year provided you have used it for 30 days before buying it; and
  - c. Self-education programs; and
  - d. Medicare Part D benefits will not be duplicated by the benefits of this policy.
5. Chiropractors' services that are within the scope of their license. Services must be medically necessary. This policy will ***not*** cover long term and/or maintenance care/therapy.
6. Foreign Travel Expenses: See your Schedule of Benefits for detailed coverage amounts. Physicians Plus will cover up to the policy maximum per your schedule of benefits for medically Necessary Hospital Services, Medical Services and Medical Supplies and services that you receive as emergency medical care in a foreign country as a result of an injury or illness of sudden and unexpected onset.

Benefits are limited to the following limitations:

  - a. Limits listed in your Schedule of Benefits; and
  - b. The care must be a Medicare Eligible Expense. This means that care would be covered if provided in the United States; and
  - c. Follow-up care must be provided in the United States; and
  - d. You must satisfy a separate deductible; and
  - e. Physicians Plus will pay 80% of the Medicare Eligible Expense per incident up to the applicable Lifetime maximum; and
  - f. All claims must be submitted in English and converted into U.S. dollars.
7. Please refer to your Schedule of Benefits for other services covered under this policy.

## **6. GENERAL EXCLUSIONS**

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### **EXCLUSIONS:**

#### **Physicians Plus does not cover the following:**

- a. Services and supplies provided while a member's coverage was not in effect under this policy.
- b. Any costs that Medicare has paid.
- c. Treatment, services and/or supplies that Medicare does not cover, including drugs provided in connection with such treatment, services and/or supplies, except as specifically provided by this policy including schedule of benefits.
- d. Any treatment, service and/or supply not specifically identified as covered by this policy; or 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.
- e. Services performed by a non-participating provider.
- f. Complications related to cosmetic body piercing, tattooing, implants or other services or procedures that are not medically necessary or not performed by a licensed medical professional.
- g. Services and supplies that are not medically necessary or are not appropriate to the treatment of an illness or injury as determined by Medicare and Physicians Plus.
- h. 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 in a contested Workers' Compensation proceeding or whenever this exclusion may otherwise apply, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in this policy.
- i. For purposes of subrogation, reimbursement or reimbursement under any provision stated in this policy, the value of covered services shall be the amount Physicians Plus paid for the covered service. Where a provider is paid on a capitated basis the value shall be based upon the usual, customary and reasonable charge or the allowed amount that would have otherwise applied to that covered service at the time the claim was processed.
- j. Services, supplies or other care for injury or illness for which there is other insurance, including but not limited to non-group insurance, 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 this policy.
- k. 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 is required to carry Workers' Compensation insurance. If Workers' Compensation or any similar law protects 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.
- l. Treatment and services furnished by the U.S. Veterans Administration except when under applicable federal law. 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.
- m. 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.
- n. Reconstructive Surgery/Cosmetic Treatment, except as indicated in this policy. NOTE: Psychological reasons do not represent a medical or surgical necessity.

- o. Treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, cosmetic treatment, or reconstruction when no functional impairment exists.
- p. 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).
- q. Transportation expenses (except for covered ambulance transport as outlined in the benefits sections of this policy).
- r. Dentistry or dental or oral surgery processes, except as stated in the policy. This also excludes orthodontics, periodontics, orthognathic surgery, osteotomies and treatment for temporomandibular disorders.
- s. Care for cosmetic purposes. This does not apply to prompt repair of any accidental injury or to care that improves functioning of a malformed body member. Breast reconstruction of affected tissue incident to a mastectomy is not considered treatment for cosmetic purposes. (Exclusion does not apply where the Women's Health and Cancer Rights Act of 1988 mandates coverage).
- t. Care that Physicians Plus determines is custodial care in any setting. This exclusion does not apply to services for which Medicare determines eligibility for coverage.
- u. Care that is free to you or would be free if you did not have this policy; care that you are entitled to, or have paid for you, in whole or in part due to any law or regulation.
- v. Care you receive outside the United States, except as provided under the Foreign Travel benefit of this plan. Does not include care if you are not a permanent resident of the United States.
- w. Charges for the measurement, fitting and adjustment of dentures.
- x. Eyeglasses and contact lenses and the measurement, fitting and adjustment of these lenses, except for the initial lenses after cataract surgery.
- y. Service of a blood donor.
- z. Organ transplants that is not eligible for Medicare benefits. This exclusion does not apply to kidney transplants, which are subject to the policy's kidney disease limitations. For purposes of this exclusion, organ transplants include bone marrow and stem cell transplants.
- aa. Routine foot care, which is care for corns, callusities, toenails (but not the complete removal of toenails), and hypertrophy or hyperplasia of the skin of your feet. This exclusion does not apply if the services are medically necessary because you have diabetes.
- bb. Fees in excess of Medicare allowable charges except when covered by the policy.

## **7. POLICY TERMINATION, GUARENTEE ISSUE AND SUSPENSION**

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### **A. POLICY TERMINATION**

Physicians Plus may terminate or decline to renew this policy only if:

1. You fail to pay your premium within the grace period; or
2. Physicians Plus discovers that you misrepresented information that is material to our acceptance of the risk up to 2 years after the policy is issued.

If Physicians Plus terminates this policy for any reason other than your failure to pay your premium, we will notify you in writing at least 10 days before the termination date.

This policy provides for midterm cancellation at the request of the member or authorized representative. If the member cancels a policy midterm or the policy terminates midterm because of the member's death, Physicians Plus will issue a prorated refund to the member or the member's estate.

### **B. EXTENSION OF BENEFITS**

If you are totally disabled on the date this policy terminates, benefits may be extended for any continuous loss that commenced while the policy was in force. Benefits will continue only in the event of your continuous total disability. Premium is due for any coverage extended under this provision. This extension of benefits shall end on the earliest of the following:

1. The date your continuous total disability ends, as determined by Physicians Plus;
2. The end of the benefit period that commenced while the policy was in force; and
3. Payment of the maximum benefits under the policy.

Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

### **C. GUARANTEE ISSUE**

In some situations you have the right to enroll in a Medicare supplement or Medicare select policy regardless of your health status if your other health coverage terminates. As required by the guarantee issue provisions Physicians Plus will offer a policy without answering health questions if the following apply:

- Your Medicare Advantage or Medicare cost plan (neither is offered by Physicians Plus) stops participating in Medicare or providing care in your service area; or
- You move outside the plan's geographic service area; or
- You leave the health plan because it failed to meet its contract obligations to you; or
- Your employer group health plan ends some or all of your coverage; or
- Your Medicare supplement insurance company ends your Medigap or Medicare select policy and you're not at fault (for example, the company goes bankrupt); or
- You drop your Medigap policy to join a Medicare Advantage plan, a Medicare cost plan, or buy a Medicare select policy for the first time, and then leave the plan or policy within one year (12 months) after joining. However, you may only return to the policy under which you were originally covered, if available; or
- You join a Medicare Advantage plan or a Medicare cost plan and within one year of joining, you decide to leave the health plan; or
- You have Medicare Parts A and B and are covered under Medical Assistance and lose eligibility in Medical Assistance (see SUSPENSION - MEDICAID AND GROUP COVERAGE).

When you meet the above conditions and you must apply for your new Medigap policy no later than 63 calendar days after your health plan or policy ends. Physicians Plus cannot deny you insurance coverage or place conditions on the policy; and must cover you for all *preexisting conditions*, and cannot charge you more for a policy because of past or present health problems.

The insurance company terminating coverage must provide a notification that explains individual rights to guaranteed issue of Medigap policies. You must submit a copy of this notice or other evidence of termination with the application for the new policy.

**D. SUSPENSION - MEDICAID AND GROUP COVERAGE**

If you become entitled to Medicaid benefits or a Group Health Plan, you may ask us to suspend this policy. Physicians Plus must receive your request for a suspension within 90 days after the date you become entitled to Medicaid or Group coverage:

1. Medicaid Coverage - Physicians Plus will suspend this policy for up to 24 months for Medicaid entitlement, effective the first of the month following our receipt of your request for suspension. If you lose your Medicaid entitlement coverage during that time, Physicians Plus will reinstate this policy as of the date your Medicaid entitlement coverage ends if you: (1) Give Physicians Plus notice within 90 days of termination of the Medicaid or Group coverage termination; and (2) Pay current premium for the policy.

2. Group Health Plan Coverage - Physicians Plus will suspend this policy when you become eligible for group coverage. The suspension will be effective the first of the month following our receipt of your request for suspension. If you lose your Group coverage during that time, Physicians Plus will reinstate this policy as of the date your Group coverage ends if you: (1) Give Physicians Plus notice within 90 days of termination of the Group coverage termination; and (2) Pay current premium for the policy.

Your reinstated coverage will be equivalent to the coverage in effect before the suspension. The appropriate Medicare deductibles and benefit changes will apply. The premium rate changes will apply for your reinstated coverage and will be the same as those with the same coverage in the same age band.

## 8. PAYMENT OF CLAIMS

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### HOW TO CLAIM BENEFITS

#### 1. Notice Of Claim

When you seek health care services from a provider, always show your Medicare I.D. card and your Physicians Plus I.D. card.

#### 2. Medicare Filing

Claims for services that are eligible for reimbursement under Medicare must be sent to and processed by Medicare before Physicians Plus can process the claim(s). Normally the provider of service will send the claim to Medicare first and then to Physicians Plus. If your provider does not submit the claim to Medicare and Physicians Plus on your behalf, Physicians Plus will need the following information to process your claim:

- a. A copy of the Explanation of Medicare Benefits (EOMB); and a copy of the provider's itemized bill on a standard claim form.

Please keep copies for your records.

#### 3. Proof of Loss

Whether you submit a claim to Physicians Plus and/or Medicare or the provider of service submits the claim on your behalf; Physicians Plus must receive proof of the charges for the services you received within 12 months of the date of service or 12 months from the date Medicare made payment.

Claims that are sent to us more than 12 months after you receive care will not be paid by this policy.

#### 3. Explanation of Benefits

When a claim is submitted to Medicare; Medicare determines payment and will send to you an explanation of your benefits called a *Medicare Summary Notice*. This document explains what Medicare paid and any balance due on the claim submitted.

Your physician's office, hospital or facility will get a copy of the Medicare Summary Notice and then submit the remainder of the charges with a copy of the Medicare Summary Notice to Physicians Plus on your behalf. Physicians Plus will process the claim according to your benefits. If there is a balance due, we will send a Physicians Plus Explanation of Benefits (EOB). If there is no balance due, we will not send an explanation of benefits.

## **9. APPEAL PROCESS**

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The Physicians Plus Appeal Process encompasses all levels of appeal including, but not limited to, Complaints, Grievance and OCI Complaints.

### **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 a representative may file a grievance with Physicians Plus.

### **GRIEVANCE PROCESS**

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  
Attn: Grievance Administrator  
22 East Mifflin Street, Suite 200  
PO Box 2078  
Madison, WI 53701-2078

Except for an expedited grievance (described below), Physicians Plus will acknowledge receipt of your grievance within five business days of receipt. Our acknowledgement letter will: (1) state the specific reason for our denial of a claim or benefit or our initiation of disenrollment proceedings; and (2) inform you of when your grievance will be heard by the Grievance Committee (which will be at least seven days after the date of our acknowledgment letter).

Except for an expedited grievance (described below), you (or an authorized representative) will have the right to participate in the Grievance Committee meeting or attend by teleconference to present written or oral information. If you choose to participate (or have your authorized representative participate) in the Grievance Committee hearing, you must notify Physicians Plus no less than four business days prior to the date of the hearing.

Typically within 30 days of our receipt of your grievance, Physicians Plus will notify you in writing of the decision made by the Physicians Plus Grievance Committee. In some situations Physicians Plus may need additional information and/or time to make a decision. In those cases, before the 30-calendar day period has expired, Physicians Plus will notify you that an additional 30 calendar days will be needed to render a decision. The Grievance Committee's decision will inform you of the disposition of your grievance and of any corrective action taken on your grievance.

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 you have an "expedited grievance," Physicians Plus will resolve that grievance as expeditiously as your health condition requires but not more than 72 hours after Physicians Plus' receipt of the grievance. An "expedited grievance" means a grievance where any of the following applies:

1. The duration of the standard grievance process will result in serious jeopardy to your life or health or your ability to regain maximum function;
2. In the opinion of a physician with knowledge of your medical condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; or
3. A physician with knowledge of your medical condition determines that the grievance shall be treated as an expedited grievance.

When you need to request review of an expedited grievance: (a) prominently identify your written grievance as an "EXPEDITED GRIEVANCE" and (b) immediately contact (or have your physician immediately contact) Physicians Plus at (608) 282-8900 or (800) 545-5015.

## **INDEPENDENT REVIEW PROCESS**

What is an independent review?

The independent review process gives you the opportunity to have medical professionals that have no connection to Physicians Plus review your dispute of an "Adverse Determination" or "Experimental Treatment Determination" (defined below). For multiple family member disputes, each member must meet the criteria and submit the necessary fees. The dispute must involve an adverse determination or experimental treatment determination made by Physicians Plus. This includes denials of coverage for treatment because we maintain that the treatment is not medically necessary or that it is experimental, including a denial of your request for out-of-network services when you believe that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under your insurance policy. Also, the total cost of the denied coverage must exceed \$274.00 (this dollar amount is set by the Office of the Commissioner of Insurance annually).

You or your authorized representative must request an Independent review within 4 months from the date of the adverse determination or experimental treatment determination made by Physicians Plus or 4 months from the date of receipt of the Grievance Committees decision, whichever is later.

You will choose the Independent Review Organization ("IRO") from a list of review organizations certified by the Office of the Commissioner of Insurance for the State of Wisconsin (OCI) see the list of IRO's on our website at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com) or OCI's website at [www.oci.wi.gov](http://www.oci.wi.gov) if you do not have access to these websites you may contact Physicians Plus for a current IRO listing.

The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether Physicians Plus should cover the treatment and/or services. Pursuant to Section 632.835(3)(f) of the Wisconsin Statutes, the IRO's decision is final and binding on you and Physicians Plus.

"Adverse Determination" means a determination by or on behalf of Physicians Plus to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay, or a treatment that is a covered benefit has been reviewed and denied;
2. Based on the information provided, we have determined that the treatment or care does not meet the requirements of your health benefit plan for medical necessity, medical appropriateness, proper health care setting, level of care, or effectiveness of care;
3. Based on the information provided, we reduced, denied, or terminated the treatment or care or the payment for the treatment or care;
4. The amount of the reduction or the cost or expected cost of the denied or terminated treatment or care, or course of treatment or care will exceed \$274.00; and

5. The reduction, denial or termination has been through all levels of the Physicians Plus Grievance Process, except if the criteria for an Expedited Independent Review is satisfied (see "Expedited Independent Review" below).

Experimental Treatment Determination means a determination by or on behalf of Physicians Plus to which all of the following criteria apply:

1. A proposed treatment has been reviewed;
2. Based on the information provided, the proposed treatment is determined to be experimental according to the terms of your health benefit plan;
3. Based on the information provided, we denied the proposed treatment or payment for the proposed treatment;
4. The cost or the expected cost of the denied treatment or payment will exceed \$274.00; and 5. The denial of the proposed treatment has been through all levels of the Physicians Plus Grievance Process, except if the criteria for an Expedited Independent Review is satisfied (see "Expedited Independent Review" below).

When can I request an independent review?

When we make an Adverse Determination or an Experimental Treatment Determination and the cost of the denied coverage exceeds \$268.00, you are entitled to an independent review. You or your authorized representative must request an Independent review within 4 months from the date of the adverse determination or experimental treatment determination made by Physicians Plus or 4 months from the date of receipt of the Grievance Committee's decision, whichever is later.

Please Note: Expedited Independent Review-you may qualify for an expedited independent review if you meet the following criteria. Under Section 632.835(2)(d) of the Wisconsin Statutes, if either of the following conditions applies, you will not have to exhaust the Physicians Plus Grievance Process before you are entitled to the independent review process:

1. You (or your authorized representative) and Physicians Plus agree that the appeal should proceed directly to independent review; or 2. The IRO determines that your health condition is such that requiring you to first complete the Physicians Plus Grievance Process would jeopardize your life or health or your ability to regain maximum function.

If you wish to request an Expedited Independent Review, you should submit your request to the IRO selected by you, and you must send a notice of your request to Physicians Plus at the same time.

How do I request an independent review?

When requesting an independent review, you or your authorized representative(s) must send to Physicians Plus a written request for the independent review. You or your authorized representative must request an independent review within 4 months from the date of the adverse determination or experimental treatment determination made by Physicians Plus or 4 months from the date of receipt of the Grievance Committee's decision, whichever is later. Your request must be in writing and must:

1. Identify your name and member number, dates of service, provider of service and any other pertinent information used to identify the issue;
2. Identify the name and address of the IRO that you have selected (a list of review organizations, certified by OCI, is available on line at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com) or from OCI at [www.oci.wi.gov](http://www.oci.wi.gov); and

The IRO will make a determination within 30 days (or, in the case of an Expedited Independent Review, within 72 hours of receiving all information it needs) and notify the member and Physicians Plus. If the IRO determines that the review is not related to an Adverse Determination or Experimental Treatment, the IRO will provide the member, Physicians Plus, and OCI with written notification within two days of receiving the request for review.

**OFFICE OF THE COMMISSIONER OF INSURANCE**

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

Office of the Commissioner of Insurance  
Complaints Department  
121 E. Wilson 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.

## **10. GENERAL CONDITIONS**

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### **A. PREMIUM RATES:**

Physicians Plus determined the premium rate for this policy before accepting your application. Physicians Plus may change the rate as allowed under this policy and will notify you of the change at least 30 days in advance of the rate change. If the premium rate change is greater than 25%; we will notify you at least 60 days in advance of this rate change.

### **B. PREMIUM NOTICES:**

Physicians Plus will bill you appropriately according to the payment option you choose at the time of enrollment. If you are on an electronic funds transfer (EFT) you may not receive a monthly invoice.

### **C. PERIODS OF COVERAGE:**

The period of coverage for this policy is annual with a renewal date of January 1.

### **D. PREMIUM DUE DATE:**

This policy is in force for the initial period of coverage through the month in which you have paid your premium. The benefits of this policy run on a calendar-year basis (January-December). Premiums are due by the 1<sup>st</sup> day of the month of coverage or billing period. If you do not pay your premium for a given billing period by the end of the grace period, this policy will terminate retroactive to the last day of the month for which the required premium has been paid.

### **E. GRACE PERIOD:**

A 31-day grace period will be provided. If the required premium is not received by the end of the grace period, Physicians Plus will terminate your coverage retroactive to the last day of the month for which the required premium has been paid.

### **F. MID-TERM CANCELLATION:**

This policy provides for midterm cancellation at the request of the member or authorized representative. If the member cancels a policy midterm or the policy terminates midterm because of the member's death, Physicians Plus will issue a prorated refund to the member or the member's estate.

### **G. BENEFIT CHANGES:**

Benefits under this policy will change automatically to coincide with changes in the deductibles and/or copayments set by the Center for Medicare and Medicaid Services (CMS).

### **H. RENEWAL TERMS**

This policy is guaranteed renewable for life subject to the timely payment of premium. Physicians Plus will not cancel nor non-renew your policy for any reason other than non-payment of premium; material representation; or if you establish residency outside of the state or Physicians Plus service area. Your policy may be revised to comply with federal or state law. This policy cannot be cancelled or non-renewed solely on the grounds of your health.

### **I. DISENROLLMENT PROVISION**

Physicians Plus may terminate your coverage and disenroll you 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 met the lifetime limits of the policy;
- (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 I.D. card to obtain services;
- (E) The member is unable to establish or maintain a physician-patient relationship with the member's PCP;
- (F) Physicians Plus has not renewed the policy for all Medicare supplement members; or

(G) The member establishes residence outside of the state of Wisconsin or Physicians Plus service area.

Disenrollment for reason (E) shall occur only after Physicians Plus has provided the member with the opportunity to select an alternate PCP; made a reasonable effort to assist the member in establishing a physician-patient relationship. 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.

#### **J. REINSTATEMENT**

Reinstatement is subject to our right to change or terminate this policy. (See Renewal Terms, above). If you end this policy by not paying your premium, you may apply for it to be reinstated. The following rules apply:

1. (a) your coverage must have lapsed due to non-payment of premium; (b) you must apply for reinstatement within 1 year of the lapse date; and (c) you want to reinstate the same coverage you had.
2. Physicians Plus must approve your application to reinstate. Physicians Plus can either approve or decline it.
3. If Physicians Plus agrees to reinstate coverage charges and/or losses resulting from services and/or injuries occurring during the lapse of coverage period will not be covered.
4. If approved, the new policy will be effective on the first day of the month following approval, provided the required quarterly premium has been paid.
5. Physicians Plus will not accept monthly payments for reinstatement applications when terminated due to non-payment of premium. You must pay premiums for the new policy quarterly.

#### **K. YOUR RELATIONSHIP WITH HEALTH CARE PROVIDER**

Physicians Plus will not alter or interfere with the professional relationship you have with your physician or hospital.

Physicians Plus is not responsible for any injury, damage or expense (including attorneys fees) a member suffers as a result of any improper advice, action or omission on the part of any physicians, hospital or other health care provider. Physicians Plus is obligated to provide only the benefits specially stated in the policy.

#### **L. NON-ASSIGNMENT**

##### **1. Non-Assignment of Benefits**

Only you are entitled to coverage under this policy. You cannot transfer or assign your right to receive services, in whole or in part, to anyone.

##### **2. Non-Assignment of Compensation**

Subject to federal law requiring direct payment to certain providers of services, only you can be compensated for services covered under this policy. You cannot assign your right to compensation for services performed, or to be performed, to any provider of service. However, Physicians Plus may pay the provider directly.

#### **M. CONSENT AND AUTHORIZATION**

When you enter into this contract, you agree to the following:

##### **1. Release of Information**

You agree to cooperate in providing us with information Physicians Plus needs to pay claims. This includes agreeing to sign authorizations to the release by hospitals and physicians of your patient health care records.

##### **2. Subrogation**

You are subject to subrogation for damages, reimbursement, or payment that arise out of an illness or injury, to the extent of the value of the covered services received for the illness or injury. You agree that those rights are assigned to us. Those assigned rights include, but are not limited to, rights against:

- a. Any automobile liability insurance;
- b. Any underinsured or uninsured motorist insurance;
- c. Where permitted by state law, any automobile medical payments or no-fault/personal injury protection insurance;
- d. Any homeowner liability insurance;
- e. Any applicable umbrella insurance;
- f. Medical malpractice insurance or patient compensation fund insurance; and
- g. Anyone liable for paying losses or damages.

You agree that you will not include in your claim for damages, reimbursement or payment from any person, organization or insurer, that portion of their claim that has been transferred and assigned to us. You also agree to cooperate with us in any effort to recover the value of covered services received by you. Such cooperation shall include, but not be limited, to providing us with reasonable prior notice of an opportunity to participate in any such claim or settlement of such claim. You agree to do nothing at any time, to compromise, hinder or prejudice our right of recovering including entering into a settlement agreement without our written consent. If you do anything to prejudice our right of recovery, such act shall constitute a breach of this contract. Our right of recovery is not prejudiced if its cause of action is not extinguished. Physicians Plus has the right to recover from anyone, including any person, organization or insurer. However, Physicians Plus may not recover from you unless you have been made whole in the complete and final resolution of a claim. Whether you have been made whole takes into account your degree of fault. Any dispute as to whether you have been made whole shall be resolved by a judicial and/or jury determination. Such determination shall be conducted as any other civil jury trial. The rules of evidence shall govern the determination and the fact finder shall determine the dollar amount that makes you whole.

### **3. Worker's Compensation**

This contract is separate from Worker's Compensation insurance. It does not satisfy any legal requirement for that insurance.

If you receive covered services for any illness or injury for which you are or would have been eligible for an award, settlement or compromise, in whole or in part, under any Worker's Compensation or Employer Liability Law, you consent to our direct reimbursement out of the proceeds available or which would have been available under such law to the extent of the value of the covered services you receive.

### **4. Value Of Covered Services**

For purposes of subrogation, reimbursement or reimbursement under any Worker's Compensation or Employer Liability Law, the value of covered services shall be the amount Physicians Plus paid for the covered service. Where a provider is paid on a capitated basis, the value shall be based upon the Usual, Customary and Reasonable Charge or the allowed amount that would have otherwise applied to that covered service at the time the claim was adjudicated.

### **5. Mistakes In Benefit Payments**

If Physicians Plus provides benefits to you by mistake, you agree to repay the value of those benefits as soon as you are aware of the error.

## **N. MISSTATEMENTS**

After this policy is in effect 2 years, Physicians Plus cannot cancel your policy or deny your claim because of a misstatement in your application.

## **P. NOTICES**

Any notice you send to us must be mailed to the address shown on the last page of this policy. Any notice Physicians Plus sends to you will be mailed to your last known address as shown in our records. Please keep your information up to date.

**Q. INFORMATION**

If you have any questions concerning your membership, your coverage, or any other provisions of your policy, please direct your inquires to our Member Service department.

**R. ENTIRE AGREEMENT**

This policy together with your application and schedule of benefits is the entire agreement between you and Physicians Plus. It is a legal contract that can only be changed by a policy amendment. It takes the place of any other policies or contracts Physicians Plus has previously issued to you.

**S. MID-TERM CANCELLATION**

This policy provides for midterm cancellation at the request of the member or authorized representative. If the member cancels a policy midterm or the policy terminates midterm because of the member's death, Physicians Plus will issue a prorated refund to the member or the member's estate.

## 11. DEFINITIONS

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The following defined terms are used in this Policy:

**Adverse Determination** means a determination that involves all of the following:

1. Review of an admission to, or continued stay in, a health care facility, the availability of care or other treatment that is described as a covered service;
2. Based on the information provided, a determination that the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. As a result, the benefit for the treatment was reduced, denied, or terminated.

**Attending Physician** means a licensed medical doctor who coordinates a member's care in connection with an injury or an episode of illness.

**Benefit Period** is the way Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility (SNF) and ends when you haven't received any hospital or skilled care in a SNF for 60 days in a row.

**Calendar Year** means the period starting on the date your policy is effective as shown on your Physicians Plus I.D. card and ending on December 31 of that year. Each following calendar year will start on January 1 and end on the following December 31.

**Certificate** means the document issued by us to you. It, together with the Schedule of Benefits provides evidence of coverage and describes the benefits provided by the policy.

**Charge** means the amount that the provider has agreed to accept as payment in full for a treatment, service or supply. This amount includes any coinsurance, copayment or deductible the member is obligated to pay under the policy. The "Charge" may be different than the providers "Billed Charges" or the "Covered Charge". Charges for hospital or other institutional confinements are considered to be incurred on the date treatment, service or supply was provided. The benefit levels that apply on the hospital admission date apply to the charges incurred for the entire confinement regardless of changes in benefit levels during the confinement.

**Coinsurance** means the amount of the Medicare eligible expenses that you would be responsible for paying in the absence of this supplement policy.

**Complaint** means any dissatisfaction about Physicians Plus or our contracted providers expressed by a member (not in writing).

**Confinement** means the period starting with a member's admission on an inpatient basis to a hospital or other facility for treatment of an illness or injury and ending with the member's discharge from the same facility. However, if the member is transferred to another facility for continued treatment of the same or related illness or injury, it will be considered one confinement.

**Covered Service** means a specified service or supply for which Physicians Plus will pay benefits subject to the terms and conditions of this Policy.

**Custodial or Maintenance Care** means care which can be learned and performed by a person who is not medically trained or care which involves the maintenance of basic bodily functions whether by natural or artificial means; care which includes care required for patient safety; and care which includes respite care, which is care that is requested to give temporary relief to persons who normally assist with the care of the member.

In the case of confinement in a hospital or skilled nursing care facility:

- Room and board; Nursing care; physical medical services; and assistance with activities of daily living, which is provided to an individual for whom it cannot be reasonably expected that: The treatment will enable that person

to live outside an institution; or the individual has reached the maximum level of improvement or plateau in progress.

In the case of home care services, including but not limited to:

- Nursing care; physical medical services; and assistance with activities of daily living, when the member has achieved a maximum level of improvement or plateau in progress as determined by Physicians Plus.

Examples of custodial or maintenance care include, but are not limited to the following:

- (A) Services provided in an assisted living center or residential facility or assisted living within the home;
- (B) Assistance with activities of daily living (ADL) and homemaking services, such as shopping, housekeeping and laundry;
- (C) Administration of medication, eye drops or ointments;
- (D) Entertainment or recreation therapy;
- (E) Treatment of minor skin problems and wounds that do not require surgical procedures or injectable antibiotics;
- (F) Treatment of chronic bed or pressure sores when it cannot be reasonably expected that the treatment will either:
  - 1) Improve the function of the individual; or 2) Have a reasonable chance to heal the sore;
- (G) Checking vital signs when the medical condition is stable;
- (H) Checking routine or maintenance oxygen levels;
- (I) Routine or maintenance nebulized treatments;
- (J) Irrigation and other routine care of catheters;
- (K) Maintenance care of ostomies;
- (L) Routine use and care of feeding tubes;
- (M) Routine care of braces and similar devices;
- (N) Administration of routine or maintenance subcutaneous insulin;
- (O) Routine or maintenance blood sugar level; and
- (P) Maintenance bowel program.

This list is not intended to be complete. Medicare will determine whether certain other services will meet the criteria for custodial or maintenance care.

**Deductible** means the amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A or each year for Part B.

**Durable Medical Equipment:** Medically necessary equipment that can withstand repeated use, is used to serve a medical purpose for injury or illness, and is appropriate for home use. This cannot be used for personal convenience, as determined by us.

**Effective Date** means the date shown on our records on which your coverage under this Policy becomes effective.

**Emergency Medical Care** means medical services provided to a member by a physician or other medical professional licensed by the state in which the care is provided in connection with an emergency medical condition. "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to your health;
2. Serious impairment to your bodily functions; or
3. Serious dysfunction of one or more of your body's organs or parts

Emergency medical care does not include routine health maintenance services or routine medical exam.

**Experimental/Investigational** means devices, drugs, or procedures which meet one or all of the following criteria:

1. Full and final approval has not been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;
2. Specific evidence shows that the drug, device, treatment or procedure is being provided subject to: A phase I or phase II clinical trial or the experimental arm of a phase III clinical trial; a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis; or a protocol approved by and under the supervision of an Institutional Review Board;
3. The published authoritative medical and scientific literature; Has not defined or supports further research to define the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis; does not demonstrate clinically significant improvement in the efficacy or outcomes for the drug, device, treatment or procedure compared to standard drugs, devices, treatments, or procedures.

**Home Health Care** means medically necessary care provided to you when you are confined to your home under a specific plan. The plan must be made and approved in writing by your attending physician and must be reviewed at least every two months. It must involve part-time skilled nursing care, physical therapy or speech therapy performed by a Medicare approved agency.

**Hospital** means an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major medical facilities and services and must qualify as a Hospital under Medicare. A hospital also includes a specialty hospital approved by us and licensed and accepted by the appropriate state or regulatory body. It can't be (a) a convalescent or extended care facility within or affiliated with a hospital; (b) a nursing, rest or convalescent home, or extended care facility; (c) an institution operated mainly for care of the aged or for treatment of drug addiction or alcoholism; or (d) a facility primarily providing custodial, educational or rehabilitative care.

**Illness** means a bodily disorder, disease, mental illness first contracted and treated on and after the effective date of the policy.

**Injury** means bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes of loss.

**Inpatient** means admission as a bed patient to a hospital or a skilled nursing facility and does not include observation.

**Lifetime Reserve Days** – Sixty additional days that Medicare will pay for when you are in a hospital for more than 60 days. These 60 reserve days can be used only once during your lifetime.

**Medical Service** means those professional services, including medical, surgical, diagnostic, therapeutic and preventive services, which are performed, prescribed or directed by a Physician. It also includes the services of podiatrists, chiropractors, optometrists, and dentists acting within the scope of their respective licenses.

**Medical Supplies and Services** means prosthetic appliances, durable medical equipment, diabetic equipment and supplies, ambulance service, and any other Medically Necessary items provided to You that are eligible as covered items under Medicare Part B or this Policy.

**Medical Supplies** apply to items, which are:

1. Primarily used to treat an illness or injury;
2. Generally not useful to a person in the absence of an illness or injury;
3. The most appropriate items that can be safely provided to a member in the most cost effective manner;
4. Prescribed by a physician;
5. Not primarily for comfort or convenience.

**Medically Necessary (Medical Necessity)** means the services, supplies or equipment provided by a hospital, physician, other provider or pharmacy that are required to diagnose or treat your illness or injury.

**Medicare** means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**Medicare Eligible Expenses** means health care expenses that are covered by Medicare, recognized as medically necessary and reimbursable by Medicare, and that may or may not be fully reimbursed by Medicare.

**Medicare Select Plan** is a plan offered by Physicians Plus in which you pay a set premium each month for all covered services. You **MUST** obtain covered services from a participating provider.

**Open Enrollment Period** means the first 6 months following your enrollment in Medicare Part B or the first 6 months following your 65<sup>th</sup> birthday if your Medicare Part B was effective before your 65<sup>th</sup> birthday.

**Participating Hospital** means a hospital or hospitals that have agreed in writing by signing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Physicians Plus members enrolled in a Select Medicare Supplement Policy. The hospital's written participation agreement must be in force at the time such services supplies or items are provided to you.

**Participating Physician** means a physician participating in Physician Plus' network at a location approved by us, to provide covered medical services to members enrolled under the Select Medicare Supplement Policy. The participating physician's written participation agreement must be in force at the time such services supplies or items are provided to you.

**Participating Provider** means a provider who has agreed in writing by executing a participation agreement with us to provide, prescribe, or direct health care services to Physicians Plus Insurance Corporation member's enrolled in a Medicare Supplement Policy. The participating provider's written participation agreement must be in force at the time such service, supplies or items are provided to you.

**Primary Care Physician (PCPs)** means a participating physician from the list of PCPs Physicians Plus makes available to you or other selected physicians as determined by Physicians Plus. Members enrolled in a Select Medicare Supplement Policy, but not in a Traditional Medicare Supplement Policy, must name a PCP on your enrollment application or in a later written notice of change. A member's PCP will:

1. Manage the member's health care;
2. Give the member profession service;
3. Prescribe other medical services and medical supplies; or
4. Refer the member to other physicians.

The PCP may belong to a medical group that has specific referral or prior authorization requirements unique to the PCP's medical group. The member participating in the Select Medicare Supplement Policy may be required to obtain specialty care only from specialists who belong to the same medical group as the PCP.

**Physician** means any of the following persons, who in each case is licensed and/or legally authorized by the State in which he or she practices to perform the services he or she provides, and is practicing within the scope of that license or authorization:

- M.D.-Doctor of Medicine.
- D.O.-Doctor of Osteopathy.
- D.D.S.- Doctor of Dental Surgery.
- D.D.M.-Doctor of Dental Medicine.
- D.P.M.-Doctor of Podiatric Medicine.
- O.D.-Doctor of Optometry.
- D.C.- Doctor of Chiropractic.

**Physicians Plus** means Physicians Plus Insurance Corporation.

**Physicians Plus Insurance Corporation** means a stock insurance corporation with its principal office in Madison, Wisconsin, organized and existing under Chapter 611 of the laws of Wisconsin.

**Policy** means the agreement between Physicians Plus and the Physicians Plus member to provide health insurance coverage. The policy consists of the application, schedule of benefits, this Medical Certificate, any amendments and/or riders.

**Psychiatric Care** means care for any condition classified as neurosis, psychoneurosis, psychopathy or psychosis.

**Prior Authorization** means a written or verbal communication from us to a member, provided BEFORE a member receives treatment, services or supplies stating that the treatment, services or supplies will be covered benefits under the policy, subject to other applicable provisions.

**Service Area (Physicians Plus)** means Columbia, Dane, Dodge, Green, Iowa, Jefferson, Rock and Sauk County.

**Skilled Nursing Care** means medically necessary care furnished on a physician's order that requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel. Such care may or may not be Medicare approved.

**Skilled Nursing Facility** means an institution (or part of one) that: (a) is operated pursuant to law; (b) primarily engages in providing, in addition to room and board accommodations, skilled nursing care under the supervision of duly licensed physician; (c) provides continuous 24-hours-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (d) maintains a daily medical record of each patient.

**United States/U.S.** means all of the United States of America; the District of Columbia; the Commonwealth of Puerto Rico; the Virgin Islands (American); and American Samoa.

**Usual and Customary** means the usual and customary amount payable based upon the average charge for the same service provided by other providers of a similar type, training, and experience, in the same or similar geographical area and should not exceed the fees that the provider would charge any other pay or for the same services. Other factors such as, but not limited to, complexity, degree of skill or type of provider may also determine a usual and customary fee. Usual and Customary fees apply to Wisconsin mandated benefits only.

**We, Us and Our** refers to Physicians Plus Insurance Corporation, a Wisconsin service insurance corporation.

**You, Your, and Yours** refers to the person enrolled in Part A and Part B of Medicare to whom Physicians Plus has issued this Policy.



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