equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the HEALTH PLAN.

e. Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the HEALTH PLAN. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g. Customization of buildings for accommodation (for example, wheelchair ramps).

h. Replacement or repair of Durable Medical Equipment/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10. Outpatient Prescription Drugs – Administered by the PBM

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

b. Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c. Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d. Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e. Anorexic agents.

f. Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g. All over-the-counter drug items, except those designated as covered by the PBM.

h. Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i. Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.

j. Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l. Infertility and fertility medications.

m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.

n. Charges to replace expired, spilled, stolen or lost prescription drugs.

11. General

a. Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b. Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

c. Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d. INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e. Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

f. Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the HEALTH PLAN and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h. Treatment, services or supplies used in educational or vocational training.

i. Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j. MAINTENANCE CARE.

k. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

l. Personal comfort or convenience items or services such as in-Hospital television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o. Expenses incurred prior to the coverage EFFECTIVE DATE in the HEALTH PLAN and/or PBM, or services received after the HEALTH PLAN and/or PBM coverage or eligibility terminates. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing HEALTH PLANs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding HEALTH PLAN will be the responsibility of the succeeding HEALTH PLAN unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding HEALTH PLAN'S network. In this instance, the liability will remain with the previous insurer.

p. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r. Charges for any missed appointment.

s. EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ

transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t. Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u. Services, including non-physician services, provided by NON-PLAN PROVIDERS. Exceptions to this exclusion:

   1) On written REFERRAL by PLAN PROVIDER with the prior written authorization of the HEALTH PLAN.

   2) Emergencies in the Service Area when the PRIMARY CARE PROVIDER or another PLAN PROVIDER cannot be reached.

   3) EMERGENCY or URGENT CARE services outside the Service Area. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the HEALTH PLAN.

v. Services of a specialist without a PLAN PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the HEALTH PLAN. Any Hospital or medical care or service not provided for in this document unless authorized by the HEALTH PLAN.

w. Coma stimulation programs.

x. Orthoptics (Eye exercise training) except for two sessions as MEDICALLY NECESSARY per lifetime. The first session for training, the second for follow-up.

y. Any diet control program, treatment, or supply for weight reduction.

z. Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.

ab. Services to the extent a PARTICIPANT receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means YOU are actually insured under Worker's Compensation.

ac. Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.

ad. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by a PLAN PROVIDER or Prior Authorized by the HEALTH PLAN. The treatment of the complication must be a covered benefit of the HEALTH PLAN and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

ae. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a

covered service to correct a functional impairment related to CONGENITAL bodily disorders or conditions or when associated with covered reconstructive surgery due to an ILLNESS or accidental INJURY (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

af. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.

ag. Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is EMERGENCY ambulance transportation.

ah. Sexual counseling services related to infertility.

ai. Services that a child's school is legally obligated to provide, whether or not the school actually provides the services and whether or not YOU choose to use those services.

aj. Hypnotherapy.

ak. Marriage/couples/family counseling.

al. Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.

am. Biofeedback.

B. Limitations

1. COPAYMENTS or COINSURANCE are required for:

   a. State of Wisconsin program PARTICIPANTS, except for retirees for whom MEDICARE is the primary payor, for all services unless otherwise required under federal and state law.

   b. State of Wisconsin PARTICIPANTS for whom MEDICARE is the primary payor, and for all PARTICIPANTS of the Wisconsin Public Employers program, and/or limitations apply to, the following services: Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental INJURY, Oral Surgery, Hospital Inpatient, licensed SKILLED NURSING FACILITY, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.

3. Use of NON-PLAN PROVIDERS and HOSPITALS requires prior written approval by the PARTICIPANT'S PRIMARY CARE PROVIDER and the HEALTH PLAN to determine medical appropriateness and whether services can be provided by PLAN PROVIDERS.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, PLAN PROVIDERS and HOSPITALS render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of

available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, PARTICIPANTS may receive covered services from NON-PLAN PROVIDERS and/or Non- Participating Pharmacies.

5. Circumstances Beyond the HEALTH PLAN'S and/or PBM's Control: If, due to circumstances not reasonably within the control of the HEALTH PLAN and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the HEALTH PLAN and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the HEALTH PLAN, PLAN PROVIDERS and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from NON-PLAN PROVIDERS and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a PLAN PROVIDER for determining the need for correction.

7. Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

1. This Coordination of Benefits ("COB") provision applies to This Plan when a PARTICIPANT has health care coverage under more than one Plan at the same time. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

   a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

   b. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of This Plan.

B. Definitions

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

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

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

2. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other

has been rendered in accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.