

**Wisconsin Public Employers
Group Health Insurance Program** for
Participating Local Government Employees and Annuitants



It's Your Choice 2015 Reference Guide

A resource to use throughout the year regarding
Group Health Insurance information



Scan to read online.

ET-2128r-15 (10/14)

**Turn the page
to find the information
most important to you**

The *It's Your Choice Reference Guide* is filled with information to help eligible local employees, annuitants and continuants gain essential knowledge of their benefits.

More Resources Found Online

The following section has moved from this guide to the ETF website at etf.wi.gov/members/IYC2015/IYC_Local_home.html

- Frequently Asked Questions (15ET-2128faq)

Visit the Contact ETF webpage at etf.wi.gov/contact.htm and select the Other link under E-mail Us if you need a printed copy. Once on the page, fill in the required information, select the Insurance (Health, Life) button and indicate in the Message field which section you would like mailed by including the section's form name and number, which are listed above. You may also contact ETF toll-free at 1-877-533-5020 or 608-266-3285 and select options 1, 2, 2, 1, 1 and 6 when prompted.

Be sure to read...

Annuitants:

- Medicare Information, including Parts A, B and D, and Eligibility Frequently Asked Questions online, as shown above
- Pharmacy Benefit Manager Frequently Asked Questions online, as shown above
- Family Status Change Frequently Asked Questions online, as shown above
- Uniform Benefits Schedule of Medical Benefits on Page 25

Active employees:

- Dependent Frequently Asked Questions online, as shown above
- Pharmacy Benefit Manager Frequently Asked Questions online, as shown above
- Family Status Change Frequently Asked Questions online, as shown above
- Uniform Benefits Schedule of Medical Benefits on Page 25

Information on commonly requested benefits, services

- Uniform Medical Benefits Quick Reference following the Certificate of Coverage on pages 74 and 75

Visit ETF online at etf.wi.gov

Every effort has been made to ensure that the information in this guide is accurate. In the event of conflicting information, state statute, state health contracts and/or policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.

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The *It’s Your Choice Decision Guide* and *It’s Your Choice Reference Guide* are available at etf.wi.gov. Any known printing discrepancies will be clarified on this site. Please visit the site for other information about insurance programs.

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Notice of Privacy Practices

Certificate of Creditable Coverage

COBRA: Continuation of Coverage for
Group Health Insurance

HIPAA: Privacy, Standards and Security

HIPAA: Special Enrollment Opportunities

Independent Review

Medicaid and the Children's Health
Insurance Program (CHIP)

National Medical Support Notice

PPACA: Marketplace Notice

PPACA: Patient Protection Disclosure

Women's Health Cancer Rights Act of 1998

State and Federal Notifications

Notice of Privacy Practices for the Standard Plan, State Maintenance Plan, Medicare Plus

(Administered by WPS Health Insurance)

Prescription Drug Benefit Plan

(Administered by Navitus Health Solutions)

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. The privacy of your information is important to us. Please review it carefully.

You do not need to do anything regarding this notice. It is intended to make you aware of your rights under the privacy rule of the federal Health Insurance Portability and Accountability Act (HIPAA) and to inform you how the Wisconsin Department of Employee Trust Funds uses and discloses your protected health information. Protected health information is information about you, including demographic data collected from you, that can reasonably be used to identify you and relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Please note that while ETF administers many benefit programs for state and local government employees, this notice applies to only the plans listed above. Different policies and regulations apply to records associated with other benefit programs.

**PLEASE
REVIEW THIS
DOCUMENTATION
CAREFULLY**

Our Responsibilities

ETF receives some protected health information as a necessary part of administering health benefits for members. ETF and its business associates are required by law to maintain the privacy of your protected health information, to provide you with a notice of the above plans' duties and privacy practices, and to notify affected individuals following a breach of unsecured protected health information. The term "we" in this notice means ETF and our business associates. Business associates are companies and individuals with whom ETF contracts for services, including but not limited to claim processing, utilization review, actuarial services, claim appeals services and participant surveys. In order to perform their respective functions for ETF, ETF's business associates sometimes must receive your protected health information. ETF requires a contractual commitment from all business associates to protect the privacy of any health information received in the course of providing services. The HIPAA Privacy and Security requirements that apply to ETF also apply to our business associates.

WPS Health Insurance (WPS) is the current third-party plan administrator for the Standard Plan, State Maintenance Plan and Medicare Plus. Navitus Health Solutions (Navitus) is the pharmacy benefit manager (PBM) for

State and Federal Notifications

the prescription drug benefit program. WPS and Navitus are business associates and are required to safeguard your health information according to HIPAA's privacy regulations and their respective contracts with the State of Wisconsin.

If you have health insurance with a health maintenance organization (HMO) or a preferred provider plan (PPP), you should receive a notice from your HMO or PPP regarding its privacy practices relating to your health insurance benefit.

We reserve the right to change the terms of this notice and to make the new notice provisions apply to information we already have about you, as well as to any information we may receive in the future. We are required by law to comply with the privacy notice that is currently in effect. We will notify you of any material changes to this notice by distributing a new notice to you and posting the notice on our website: etf.wi.gov.

How We May Use or Disclose Your Protected Health Information

Treatment: We may use or disclose your protected health information for treatment purposes. Treatment includes providing, coordinating or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, we may share your health information with a pharmacy in order to verify your eligibility for benefits.

Payment: We may use or disclose your protected health information for the payment of covered services that you receive under your benefit plan, or to otherwise manage your account or benefits. Payment includes activities by ETF or organizations hired by ETF to obtain

premiums, to make coverage determinations and to provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management and billing. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts. For example, we may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate the payment of your benefits. ETF is prohibited from using or disclosing protected health information that is genetic information of an individual for underwriting purposes. ETF will not disclose any psychotherapy notes regarding an individual without the individual's authorization except to defend itself in a legal action or other proceeding brought by the individual or as authorized or required by law.

Health Care Operations: We may use or disclose your protected health information to administer the plans covered by this notice and to coordinate coverage and services on your behalf. We may also use or disclose your health information during the grievance or claim review process in resolving your insurance complaints. Other examples of health care operations include:

- Quality assessment and improvement activities;
- Activities designed to improve the health plan or reduce costs;
- Reviewing and evaluating health plans, including participant satisfaction surveys;
- Training of ETF personnel and contractors;
- Transfer of eligibility and plan information to business associates (for example, to the PBM for the management of pharmacy benefits);
- Reviews and auditing, including compliance reviews, ombudsperson services, legal services and audit services;

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- Business management and general administrative activities, including customer service; and
- Fraud and abuse detection, and compliance programs.

As Permitted or Required By Law: We may share your protected health information as permitted or required by state and federal laws, including but is not limited to disclosures to comply with workers' compensation laws or similar legal programs; for U.S. Department of Health and Human Services investigations, in judicial and administrative proceedings and as required under Wisconsin law for state auditing purposes.

Organized Health Care Arrangement: We may participate in an Organized Health Care Arrangement (OHCA). An OHCA can take several forms under HIPAA, including offering health benefits under a combination of group health plans and HMOs. We may share your protected health information to coordinate the operations of the plans and to better serve you as a participant in the plans.

For Distribution of Information Related to Health Benefits and Services: We may use and disclose your protected health information to inform you of treatment alternatives or of other health related services and benefits that may be of interest to you.

Plan Sponsors: Your employer is not permitted to receive your protected health information related to the plans covered by this notice for any purpose other than the administration and coordination of your benefit plan. For example, we may disclose to your employer whether an employee is participating in the plans or has enrolled or disenrolled in any available option offered by the plans. We may disclose summary health information to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you

participate. Summary health information is data that combines information from many participants and does not include information on the individual level.

Special Circumstances: If you are unavailable to communicate, such as in a medical emergency or other situation in which you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

Authorization: We will obtain your written permission before we use or disclose your protected health information for any other purpose, unless otherwise stated in this notice. If you grant such permission, you may later withdraw your consent at anytime, in writing, using the contact information listed at the end of this notice. We will then stop using your information for that purpose. However, if we have already used or disclosed your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

Your Health Information Rights

You have rights under federal privacy laws relating to your protected health information. If you wish to exercise any of the following rights, please submit your request in writing to the ETF Privacy Officer using the contact information provided at the end of this notice. We are not required to agree to every request. We will notify you if we approve your request or explain the reason for our decision if we deny your request. We may charge you a fee to cover the costs of processing your request. If so, we will inform you of the fee before proceeding.

Restrictions/Confidential Communications: You may request that we not use your protected health information for certain treatment, payment or health care operations, or that we communicate with you using reasonable alternative means or locations.

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View or Receive a Copy of Your Health Information:

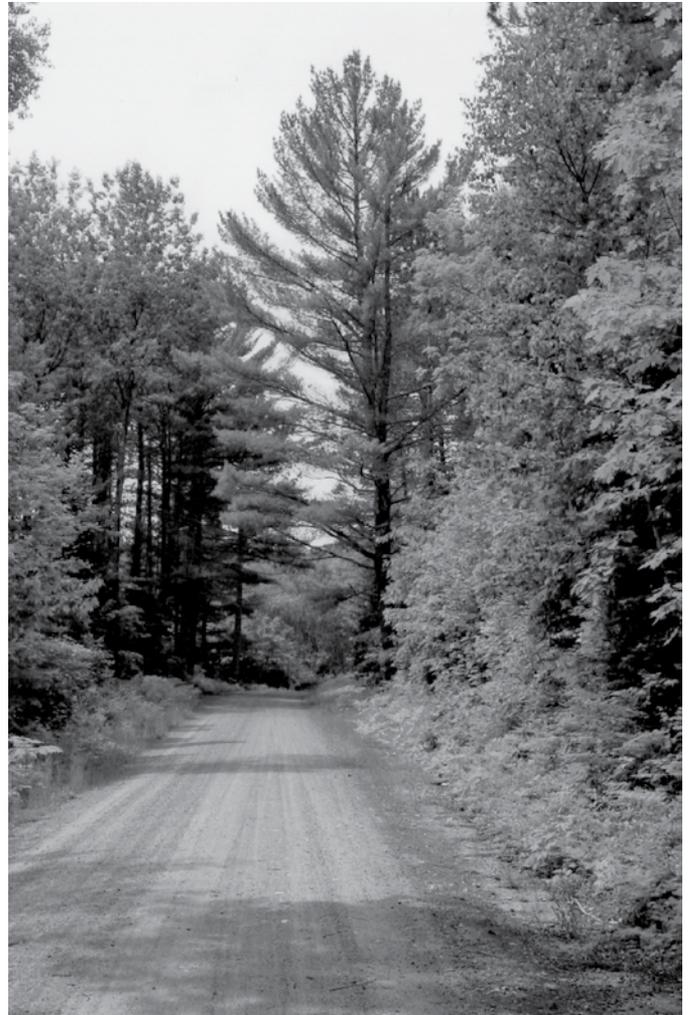
You have the right to review or obtain a copy of the protected health information that is used to make decisions about you. We are not required to give you certain information, including information prepared for use in legal actions or proceedings.

Amendment of Your Records: If you believe that your protected health information is incorrect or incomplete, you may request that your information be changed. Your request must include the reason why you believe the change should be made. In certain situations we will not amend records, such as when we did not create the records that you want amended.

Request a Listing of Who Was Given Your Information and Why: Upon request, we will provide you with a list of certain disclosures that we have made within six years of your request. The list will not include disclosures you authorized or disclosures we made for treatment, payment or health-care operations, or disclosures for which a listing is otherwise restricted by law.

Copy of the Privacy Notice: You have a right to obtain a paper copy of this notice at any time.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting ETF's Privacy Officer using



the information provided below. Federal law prohibits any retaliation against you for filing a complaint. You may also file a complaint with the federal Office for Civil Rights.

Privacy Rights Contact Information

Department of Employee Trust Funds

Phone toll free: 1-877-533-5020

Local: 1-608-266-3285

Fax: 1-608-267-0633

Mailing Address for Written Correspondence:

ETF c/o Privacy Officer

P.O. Box 7931

Madison, WI 53707-7931

Secure e-mail correspondence available at: etf.wi.gov/contact.htm, click on the "EMAIL US" link.

Office for Civil Rights

Chicago Contact Information:

U.S. Department of Health and Human Services

233 N. Michigan Ave., Suite 240

Chicago, IL 60601

Phone: 1-312-886-2359

Fax: 1-312-886-1807

TDD: 1-312-353-5693

Effective date: October 9, 2006

State and Federal Notifications



State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
<http://etf.wi.gov>

Important Notice About Your Prescription Drug Coverage and Medicare

2015 Notice of Creditable Coverage for Medicare Part D

KEEP THIS NOTICE – DO NOT DISCARD

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Wisconsin (State) or Wisconsin Public Employers (WPE) Group Health Insurance Program and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan under an individual policy. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering individual Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. The Department of Employee Trust Funds (ETF) has determined that the prescription drug coverage offered by the State and WPE programs, and administered by Navitus Health Solutions is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year after that from October 15th through December 7th. If you lose your State or WPE prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

For Medicare eligible, active working individuals enrolled in the State or WPE group health insurance program, if you decide to join a Medicare drug plan, your current State or WPE prescription drug coverage will not be affected. You can remain enrolled in the State's or WPE's plan and prescription drug coverage through the State or WPE will be primary to Medicare Part D. However, there will be no reduction in your monthly premium. If you do decide to drop your current State or WPE coverage, be aware that you and your dependents may not be able to get this coverage back. The State and WPE benefit plan design doesn't allow you to drop prescription drug coverage and maintain health benefit coverage separately. Refer to the 2015 Reference Guide (ET-2107r-15 for State or ET-2128r-15 for WPE) for more information on reenrolling in the State or WPE plan and the impact Medicare Part D has on your coverage.

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For Medicare eligible, retired, disabled and COBRA individuals who are not actively working, prescription drug coverage is provided through a Medicare Part D employer group waiver plan, Navitus MedicareRx (PDP), underwritten by Dean Health Insurance, Inc., which is considered creditable coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you drop or lose your current coverage with the State or WPE program and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join another Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join a Medicare drug plan.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact either Navitus or ETF.

Navitus Health Solutions

Phone toll free: 1-866-333-2757

Hours: 24 hours a day, 7 days a week (Closed Thanksgiving and Christmas Day)

Navitus MedicareRx (PDP)

Phone toll free: 1-866-270-3877

Department of Employee Trust Funds

Phone toll free..... 1-877-533-5020

Local to Madison..... (608) 266-3285

FAX..... (608) 267-4549

Web site..... <http://etf.wi.gov>

Mailing Address:

P.O. Box 7931

Madison, WI 53707-7931

Wisconsin Relay Service (for hearing & speech impaired)

7-1-1 or 1-800-947-3529 (English) or 1-800-833-7813 (Spanish)

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever State or WPE coverage changes. You may also request a copy of this notice from ETF at any time.

For More Information About This Notice or Your Current Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is available in the annual "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. While you may also be contacted directly by Medicare PDP providers, you can get more information about Medicare prescription drug coverage from the following sources:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of the "Medicare & You" handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE.

If you decide to join one of the Medicare prescription drug plans approved by Medicare you may need to provide a copy of this notice when you join to show that you have maintained creditable coverage and, therefore, are not required to pay a higher premium (a penalty).

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COBRA: Continuation of Coverage Provisions for the Group Health Insurance Program

This notice is provided to meet federally required notification for continuing your health insurance in the event that you or a covered dependent lose eligibility for coverage. Both you and your spouse should take the time to read this information carefully.

If active coverage is lost, the Wisconsin Public Employers (local government) Group Health Insurance Programs has routinely permitted continuation of coverage for a:

- Retired employee
- Surviving spouse of an active or retired employee
- Surviving dependent child of an active or retired employee

The coverage for a retired employee and surviving spouse may be continued for life. The children may continue coverage for only as long as they meet the definition of a dependent child. This is not considered to be continuation of coverage as discussed below.

Current federal law, known as COBRA, is somewhat more broad and requires that this notification, regarding additional continuation rights, be given to you and your spouse at the time group health insurance coverage begins. Your employer will provide you with the necessary forms. *If you choose COBRA, complete and return the forms to ETF. Do not send a check. Your health plan will bill you.*

If you are the actively employed subscriber, you have the right to apply for continuation of coverage for up to 18 months if you lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

If you are the spouse of the subscriber (active or retired), you have the right to apply for continuation if you lose coverage for any of the

following reasons:

1. The death of your spouse*
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
3. Divorce from your spouse*

Dependent children have the right to continuation if coverage is lost for any of the following reasons:

1. The death of a parent*
2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment
3. Parents' divorce*; or
4. The dependent child loses dependent status*.

* These qualifying events entitle the dependent to up to 36 months of continuation coverage.

The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status. Under the law, ETF must receive your application to continue coverage, postmarked within 60 days from the termination of your current coverage or within 60 days of the date you were notified by your employer of the right to choose continuation coverage, whichever is later. If ETF is not notified within 60 days of the date of these two events, the right to continuation coverage is lost.

Continuation coverage is identical to the former coverage, and you have the right to continue this coverage from the date of the qualifying event (for example, divorce or a dependent reaching the limiting age) that caused the loss of eligibility. However, your continuation coverage may be cut short for any of the following reasons:

State and Federal Notifications

1. The premium for your continuation coverage is not paid
2. You or a covered family member become covered under another group health plan that does not have a preexisting conditions clause which applies to you or your covered family member or
3. You were divorced from a covered employee, subsequently remarry and are covered under your new spouse's group health plan.
4. A covered member becomes entitled to Medicare benefits.

If you do not choose continuation coverage, your group health insurance coverage will end. You do not have to show that you are insurable to choose continuation coverage. However, you will be required to pay all of the premium (both your share and any portion previously paid by your employer). At the end of the continuation coverage period, you will be allowed to enroll in an individual conversion health plan. Contact your health plan directly

to make application for conversion coverage. If you are an active employee, you or your dependents should contact your employer regarding continuation (including any changes to your marital status or addresses). If you are a retired employee, you or your dependents should contact our office regarding continuation, at toll free 1-877-533-5020 or 608-266-3285 (local Madison).

See *Frequently Asked Questions* online at etf.wi.gov/members/IYC2015/IYC_Local_fa.html.



HIPAA: Privacy, Electronic Transactions Standards and Security

HIPAA administrative simplification rules are intended to simplify and streamline the health care claims and payment process through the implementation of national standards. The rules also require that your health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards and security. The privacy rule came into effect on April 14, 2003, and establishes limits on how your health information can be

used and disclosed. The transaction standards rule, which sets out uniform methods for conducting electronic transactions, was effective on October 16, 2003. The security rule requires safeguards for health information maintained in electronic form, and was effective on April 21, 2005.

If you have any questions about HIPAA and need further information, please contact the ETF's Privacy Officer toll free at 1-877-533-5020.

HIPAA: Special Enrollment Opportunities

There are certain situations where the employee may enroll as a late enrollee without preexisting condition restrictions, such as loss of other coverage, marriage and birth or

adoption of a child. (See the *Frequently Asked Question* section at etf.wi.gov/members/IYC2015/IYC_Local_fa.html)

State and Federal Notifications

Independent Review

In addition to the internal grievance process that all health plans are required to provide, federal law and Wis. Adm. Code § INS.

18.11 requires all health plans to have an independent review procedure for review of certain decisions. These include denial of, or refusal to pay for, treatment that the insurer considers to be experimental/investigational, not medically necessary, inappropriate such

as for health care setting or level of care, due to a preexisting condition exclusion denial or rescission of coverage.

The Wisconsin Office of the Commissioner of Insurance (OCI) oversees this process, which has been in place since 2002. Contact OCI at 1-800-236-8517 or your health plan if you have questions about the independent review law.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states, including Wisconsin, have premium assistance programs that can help pay for coverage using funds from the Medicaid or CHIP programs. In Wisconsin, these health care programs are known as BadgerCare Plus. The premium assistance program is known in Wisconsin as Health Insurance Premium Payment (HIPP).

In order to enroll in HIPP, you first have to enroll in the BadgerCare Plus program. If you or your dependents are already enrolled in BadgerCare Plus, the state will automatically determine your eligibility for HIPP and contact you if HIPP is available for your family.

If you or your dependents are NOT currently enrolled in BadgerCare Plus and you think you or any of your dependents might be eligible for this program, you can contact your local county or tribal human services or social services office. You may also check Wisconsin's ACCESS Web site to find out if you may qualify and to apply for the program online. The link to ACCESS is access.wisconsin.gov/, or you may call 1-800-362-3002 to request that an application form be mailed to you. Please note that if the state pays at least 80% of the cost of the premiums

for employees and their dependents, they may not qualify for BadgerCare Plus. If you reside outside Wisconsin, you can dial 1-877-KIDS NOW or visit their website at www.insurekidsnow.gov to find out how to apply in your state.

If it is determined that you or your dependents are eligible for HIPP under BadgerCare Plus, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

For more information on special enrollment rights, you can contact either of the following departments:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services
www.cms.gov
1-877-267-2323, ext. 61565

National Medical Support Notice

State and federal laws provide for a special enrollment opportunity for children in certain cases when ordered by a court. The enrollment opportunity is for eligible children who are not currently covered, and it may provide an enrollment opportunity not otherwise available. When the court orders such coverage for a child or children, a copy of the National Medical Support Notice should

be attached to the application.

If the parent named in the notice is currently enrolled, the child(ren) will be added to his or her current plan. If the parent is not enrolled, in most circumstances the issuing agency will select the plan for family coverage. If the issuing agency does not, the employee will be enrolled in our program's default plan, the Standard Plan.

Patient Protection and Affordable Care Act (PPACA)

PPACA: Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer

does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

State and Federal Notifications

the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your *It's Your Choice Decision Guide*, this

Reference Guide that includes the Uniform Benefits summary plan description, contact your health plan (contact information appears in the inside back cover of the *It's Your Choice Decision Guide*) or your benefits/payroll/personnel office.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Continued on next two pages.



State and Federal Notifications

Marketplace Notice Part B: Information About Health Coverage Offered by Your Employer

Note, you will need to take this document to your benefits/payroll/personnel office for completion if you choose to apply for coverage through the Marketplace.

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer ID number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. Zip code	
10. Who can we contact about employee health coverage at this time?			
11. Phone number (if different from above)		12. E-mail address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.
 - Some employees. Eligible employees are:
 - With respect to dependents:
 - We do offer coverage. Eligible dependents are spouses, domestic partners and children as defined in the Uniform Benefits Certificate of Coverage in this *It's Your Choice Reference Guide*.
 - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
- ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

State and Federal Notifications

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard¹?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard¹ offered *only to the employee* (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$_____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.¹ (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$_____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (mm/dd/yyyy):

¹An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PPACA: Patient Protection Disclosure

The Uniform Benefits Program offered by the HMOs and PPOs generally require the designation of a primary care provider. You have the right to designate any primary care provider (PCP) who participates in the health plan's network and who is available to accept you or your family members. If you do not choose a PCP or primary care clinic (PCC), some health plans will designate a PCP or PCC for you automatically. For information on how to select a primary care provider and for a list of the participating primary care providers, contact the health plan. Health plan contact information is available on the inside back cover of the *It's Your Choice Decision Guide*.

For children, you may designate a pediatrician as your PCP.

For women, you do not need prior authorization from the health plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan. Health plan contact information is available on the inside back cover of the *It's Your Choice Decision Guide*.

Women's Health Cancer Rights Act of 1998

This Act requires annual notification of coverage under this program for the following treatments in connection with a mastectomy: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a

symmetrical appearance; and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas. For more information, contact the health plan. Plan contact information is available on the inside back cover of the *It's Your Choice Decision Guide*.

Patient Rights and Responsibilities

Patient Rights and Responsibilities

As a participant in this health insurance program, you have certain rights and responsibilities. By becoming familiar with them, you will be able to make the most of your health care. Our goals are to strengthen your confidence in a fair, responsive and high-quality, health care system; to provide effective mechanisms to address your concerns; and to encourage you to take an active role in improving your health and health care.

You have the following rights:

- Considerate, respectful care from all members of the health care system.
- Non-discrimination consistent with state and federal law.
- To change plans annually.
- To a description of benefits presented in an understandable manner. Uniform Benefits are described in this guide. Outlines of coverage for the Standard plans are found in the *It's Your Choice Decision Guide*. If you select one of the Standard plans, you will receive a certificate of coverage that describes your benefits. Your plan may also provide additional information

regarding pre-certification requirements, etc.

- To select a primary care physician and to have access to appropriate specialty care. You have the right to a referral to a non-plan specialist for covered services if there is not a plan specialist who is reasonably available to treat your condition.
- A woman has the right to have access to an OB/GYN provider.
- A woman has the right to a minimum hospital stay of 48 hours following a normal delivery of a child or 96 hours following a cesarean delivery. The physician, in consultation with the mother, may discharge the mother and baby prior to the expiration of the minimum stay.
- To have continuous and appropriate access to a provider for the remainder of that calendar year if the provider leaves the plan (other than for misconduct, retirement or a move from the service area). A woman in her second or third trimester of pregnancy has access to that provider until the completion of postpartum care. This right only applies to providers that are listed in the available plan's provider directory available during the It's Your Choice open enrollment period.
- To have access to emergency care without prior-authorization from the plan. If it is not reasonably possible to use a plan hospital or facility, you have the right to obtain treatment at the nearest facility and have those charges covered by the plan as if you did use the plan hospital or facility (however, be aware of your responsibilities when emergency care is



Patient Rights and Responsibilities

received).

- To participate with your provider in treatment decisions.
- To confidentiality of medical information and your Social Security number.
- To execute a living will or durable power of attorney for health care if you are age 18 or older. These documents tell others what your wishes are in the event that you are physically or mentally unable to make medical decisions or choices yourself.
- To appeal any referral or claim denial through the plan's grievance process. This review will be conducted in a timely manner. Grievances related to care which is urgently needed must be reviewed by the plan within four working

days. If you have exhausted all levels of appeal available through the plan you may submit a complaint to ETF, in care of the Office of Legal Services.

You will need to submit an *ETF Insurance Complaint Form (ET-2405)*. You also have the right to request a departmental determination if you believe that a plan did not comply with its contractual obligations.

In a health care system that protects patients' rights, it is reasonable to expect and encourage patients to assume certain basic responsibilities. Greater personal involvement in your care increases the likelihood of achieving the best outcomes and helps support quality improvement and a cost-conscious environment.



Patient Rights and Responsibilities

You have the following responsibilities

- To review the *It's Your Choice Decision Guide* and information provided by your plan during the It's Your Choice open enrollment period. This information is important to determine if your plan and/or your providers will continue to be available and whether your current plan continues to best meet your needs for the following calendar year.
- To submit your application for coverage prior to the end of the enrollment period, if you select a different plan during the It's Your Choice open enrollment period.
- To select a primary care physician who will oversee your total health care and to make a reasonable effort to establish a satisfactory patient-physician relationship.
- To become involved in your treatment options and/or treatment plan.
- To become knowledgeable about your health insurance coverage and your health plan, including covered benefits, limitations and exclusions, and the process to appeal coverage decisions. If you are covered under an HMO or preferred provider plan, to also become knowledgeable about the plan's rules regarding use of network providers, prior authorizations and referrals.
- To authorize the release of relevant personal or medical information necessary to determine appropriate medical care, to process a claim or to resolve a dispute.
- To notify your plan by the next business day, or as soon as reasonably possible, if you receive emergency or urgent care from a non-plan provider.
- To promptly report any family status changes to your payroll representative (or ETF if you are an annuitant or continuant). These changes include marriage, divorce, death, a birth or adoption, or a dependent child losing eligibility. You should also report address or name changes, a change in your primary care provider and Medicare eligibility.
- To respond to the plan's annual questionnaire on eligibility for any adult dependent who may be disabled. Coverage for dependents could be lost if the questionnaire is not returned to the plan or the review is not completed.
- To notify your plan if you obtain or lose other health insurance – **including Medicare**.
- To submit claims to the plan in a timely manner, if applicable.
- To use the plan's internal grievance process to address concerns that may arise.

Certificate of Coverage

This is Your description of benefits that are administered by the Alternate Plans offering Uniform Benefits. Keep this for Your reference.

Uniform Benefits do not apply to the Standard Plan or Medicare Plus except for the prescription drug coverage that is administered through the Pharmacy Benefit Manager (PBM).

The Group Insurance Board (Board) adopted a uniform medical insurance benefits package for alternate health plans. It is called "Uniform Benefits." The purpose of Uniform Benefits is to help contain the rising cost of health insurance and simplify Your selection of a health plan. You can decide which plan to select on the basis of:

- Quality
- Cost
- Access to physicians or other health care providers
- Referral policies

Uniform Benefits does not mean that all plans will treat all illnesses in an identical manner. Treatment will vary depending on the needs of the patient, the physicians involved and the managed care policies and procedures of each Health Plan.

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I. Schedule of Medical Benefits

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

The Group Insurance Board continues to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are insured under the State of Wisconsin Group Health Insurance Program.

Note: *For Participants enrolled in a Preferred Provider Plan (WEA Trust), this Schedule of Benefits applies to services received from in-network Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers. Out-of-network deductible amounts do not accumulate to the in-network Out-of-Pocket Limit.*

Except as specifically stated for Emergency and Urgent Care (see sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless You get a Prior Authorization from Your Health Plan. Prior Authorization requirements are described in the Health Plan Descriptions section of the *It's Your Choice Decision Guide*.

Schedule of Medical Benefits: Local Participants 2015

Benefit: Participating Wisconsin Public Employers (WPE)	WPE-eligible Participants in Program Option (PO) 2 and Medicare eligible and enrolled in PO 6 and PO 7
Annual Medical Deductible applies to Out-of-Pocket-Limit (OOPL).	None
Annual Medical Coinsurance	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to Out-of-Pocket Limit (OOPL).
Annual Medical Out-of-Pocket Limit (OOPL)	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL. ¹
Routine, preventive services as required by federal law	100%
Illness/injury related services	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	\$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% to an annual OOPL of \$500 per Participant; no aggregate family limit (20% member cost to OOPL) ²
Cochlear Implants for Participants age 18 and older	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL)
Cochlear Implants for Participants under age 18	100% hospital charges hospital, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for Participants age 18 and older. One aid per ear no more than once every 3 years.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of \$1,000 per hearing aid.
Hearing Aids for Participants under age 18	As required by Wis. Stat. §632.895 (16), 100%.
Temporomandibular Joint Disorders:	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of \$1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.
Dental Implants:	100% following accident or injury up to a maximum health plan payment of \$1,000 per tooth.
Prescription Drugs:	See pages 28 and 29.

Under no circumstances will You pay beyond the federal Maximum Out-of-Pocket (MOOP) limit, which is \$6,600 single/\$13,200 family for federally required essential health benefits.

¹ Note that some services will continue to be paid by You past the OOPL, including emergency room and Level 3 prescription drug Copayments.

² Federally-required preventive services are covered at 100%

Schedule of Medical Benefits: Local Participants 2015

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

- Policy Deductible Coinsurance and medical Copayments: as described on previous page.
- Lifetime Maximum Benefit on All Medical and Pharmacy Benefits: NONE.
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: Prior Authorization may be required.
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.
- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan and hospital charges. The Participant's out-of-pocket costs are not applied to the annual Out-of-Pocket Limit. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid.
- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual Out-of-Pocket Limit. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable as described in the preceding grid and the \$1,000 limit does not apply.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services section.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.
- Vision Services: One routine exam per Participant per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)
- Oral Surgery: Limited to procedures listed in Benefits and Services section.
- Temporomandibular Disorders as required by Wis. Stat §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.
- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a Uniform Dental plan to all of its members.

Schedule of Medical Benefits: Local Participants 2015

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

- Prescription Drugs and Insulin: (Except Specialty Medications)

Note:

- Drugs that are not included on the Formulary are considered non-Preferred drugs and are not covered by the benefits of this program.
- Preventive Prescription Drugs:
 - Certain preventive prescription drugs on the PBM Formulary are covered at 100% as required by federal law.
 - Under the HDHP, preventive prescription drugs are not subject to the deductible; however, if the preventive prescription drug is not covered at 100% as required by federal law, a Copayment will be required according to the provisions of this program's benefits.
 - The PBM will publish a list of prescriptions drugs affected by these provisions.

Copayments:

Level 1 Copayment

\$ 5.00

The Level 1 Copayment applies to Preferred Generic Drugs and certain lower-cost Preferred Brand Name Drugs. Level 1 Copayments accumulate toward the Level 1/Level 2 annual Out-of-Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 drugs for that benefit year.

Level 2 Copayment

\$15.00

The Level 2 Copayment applies to Preferred Brand Name Drugs, and certain higher-cost Preferred Generic Drugs. Level 2 Copayments accumulate toward the Level 1/Level 2 annual OOPL until the Level 1/Level 2 OOPL is met after which You pay no more out-of-pocket expenses for Level 2 Drugs for that benefit year.

Level 3 Copayment

\$35.00

The Level 3 copayment applies to Non-Preferred Brand Name Drugs and certain high-cost, Generic Drugs for which alternative and/or equivalent Preferred Generic Drugs and Preferred Brand Name Drugs are available and covered. Level 3 Copayments do **not** accumulate toward an annual OOPL. You must continue to pay Level 3 copayments even after other annual OOPLs have been met.

Level 1/Level 2 Annual Out-of-Pocket Limit (OOPL)

(The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):

- \$410 per individual or \$820 per family for all Participants, except:
- \$1,000 per individual or \$2,000 per family for state and Wisconsin Public Employer Participants enrolled in the Standard Plan.

Schedule of Medical Benefits: Local Participants 2015

Specialty Medications

Level 4 Copayment

\$50.00

Preferred Specialty Medications:

The Level 4 Copayment applies when medications are obtained from a Participating Pharmacy other than a Preferred Specialty Pharmacy. Level 4 copayments for Preferred Specialty Medications accumulate toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year.

Non-preferred Specialty Medications:

The Level 4 Copayment applies whether medications are obtained at a Preferred Specialty Pharmacy or another Participating Pharmacy. Level 4 copayments for Non-Preferred Specialty Medications do **not** accumulate toward any annual OOPL. You must continue to pay copayments for Level 4 Non-Preferred Specialty Medications even after other annual OOPLs have been met.

Reduced Level 4 Copayment

\$15.00

The Reduced Level 4 Copayment applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. Reduced Level 4 Copayments accumulate toward the Level 4 annual OOPL until the Level 4 OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year. This reduced Copayment does **not** apply to Non-Preferred Specialty Medications.

Level 4 Annual Out-of-Pocket Limit (OOPL)

(The amount You pay for Your Level 4 Preferred Specialty Medications)

\$1,000 per individual or \$2,000 per family for all Participants.

Certain grandfathered erectile dysfunction medication as defined by the PBM

(Viagra and Caverject Injection): the \$50 Level 4 Copayment applies to these prescription medications. However, the copayments do *not* accumulate toward any OOPL. You must continue to pay Level 4 copayments for these drugs even after other annual OOPLs have been met.

Disposable Diabetic Supplies and Glucometers Coinsurance: 20% member Coinsurance applies to the prescription drug Level 1/Level 2 annual OOPL.

Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year. Prior Authorization is required if the first quit attempt is extended by the prescriber.

Schedule of Medical Benefits: Local Participants 2015

II. Definitions

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

- **Bed And Board:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **Benefit Period:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **Brand Name Drugs:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.
- **Comorbidity:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.
- **Confinement/Confined:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.
- **Congenital:** Means a condition which exists at birth.
- **Coinsurance:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any limits specified in the Schedule of Benefits.
- **Copayment:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any limits specified in the Schedule of Benefits.
- **Custodial Care:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a Plan Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the medical or surgical treatment will enable that person to live outside an institution. Custodial Care also includes rest cures, respite care, and home care provided by family members.
- **Deductible:** The amount You owe for health care services Your Health Plan covers before Your Health Plan begins to pay. For example, if Your deductible is \$1,500, Your plan will not pay anything until You have incurred \$1,500 in out-of-pocket expenses for covered health care services subject

to the deductible. The deductible may not apply to all services.

- **Department:** Means Department of Employee Trust Funds.
 - **Dependent:** Means, as provided herein, the Subscriber's:
 - Spouse.
 - Domestic Partner, if elected.
 - Child.
 - Legal ward who becomes a legal ward of the Subscriber, Subscriber's spouse or insured Domestic Partner prior to age 19.
 - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
 - Stepchild.
 - Child of the Domestic Partner insured on the policy.
 - Grandchild if the parent is a Dependent child.
1. A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.
 2. A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.
 3. All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:
 - a. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as long as the child remains so

disabled and he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The Health Plan will monitor eligibility annually, notifying the employer and Department when terminating coverage prospectively upon determining the Dependent is no longer so disabled and/or meets the support requirement. The Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

- b. After attaining age 26, as required by Wis.Stat. § 632.885, a Dependent includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.
4. A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The Effective Date of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.
 5. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
 6. Any Dependent eligible for benefits who is not listed on an application for cover-

Definitions: Local Participants 2015

age will be provided benefits based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the employer, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

- **Domestic Partner:** Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:
 - Each individual is at least 18 years old and otherwise competent to enter into a contract.
 - Neither individual is married to, or in a domestic partnership with, another individual.
 - The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
 - The two individuals consider themselves to be members of each other's immediate family.
 - The two individuals agree to be responsible for each other's basic living expenses.
 - The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
 - Only one of the individuals has legal ownership of the residence.
 - One or both of the individuals have one or more additional residences not shared with the other individual.
 - One of the individuals leaves the common residence with the intent to return.
- **Effective Date:** The date, as certified by the Department and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **Eligible Employee:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **Emergency:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:
 1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
 2. Serious impairment to the Participant's bodily functions.
 3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in section III., A., 1., e. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.
- **Expense Incurred:** Means an expense at or after the time the service or supply is actually provided - not before.

- **Experimental:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.
- **Formulary:** Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require prior authorization for certain Preferred and non-Preferred drugs before coverage applies. Drugs that are not included on the Formulary are not covered by the benefits of this program.
- **Generic Drugs:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **Generic Equivalent:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **Grievance:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **Habilitation Services:** Means excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- **Health Plan:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during the calendar year.
- **High Deductible Health Plan (HDHP):** A health plan that, under federal law, has a minimum annual deductible and a maximum annual Out-of-Pocket Limit (OOPL) set by the IRS. An HDHP does not pay any health care costs until the annual deductible has been met (with the exception of preventive

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services mandated by the Patient Protection and Affordable Care Act). The plan is designed to offer a lower monthly premium in turn for more shared health care costs.

- **Hospice Care:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.
- **Hospital:** Means an institution that:
 1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
 2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

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

- **Hospital Confinement or Confined In A Hospital:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

- **Illness:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **Immediate Family:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses or Domestic Partners.
- **Injury:** Means bodily damage that results directly and independently of all other causes from an accident.
- **Level “M” Drug:** Means an injectable, prescription medication covered by Medicare Parts B and D when the Medicare Prescription Drug Plan is the primary payer. Level M Drugs are required to be on the Medicare Prescription Drug Plan’s Medicare Part D Formulary but are not included on the commercial coverage Formulary. Claims associated with Level M Drugs, along with the costs to administer the injection, are adjudicated by the PBM, not the Health Plan.
- **Maintenance Care:** Means ongoing care delivered after an acute episode of an Illness or Injury has passed. It begins when a patient’s recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes “Maintenance Care” is made by the Health Plan after reviewing an individual’s case history or treatment plan submitted by a Provider.
- **Medical Supplies And Durable Medical Equipment:** Means items which are, as determined by the Health Plan:
 1. Used primarily to treat an Illness or Injury; and
 2. Generally not useful to a person in the

- absence of an Illness or Injury; and
3. The most appropriate item that can be safely provided to a Participant and accomplish the desired end result in the most economical manner; and
 4. Prescribed by a Provider.
- **Medically Necessary:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:
 1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
 2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
 3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
 4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
 - **Medicaid:** Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
 - **Miscellaneous Hospital Expense:** Means Usual and Customary Hospital ancillary charges, other than Bed And Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
 - **Natural Tooth:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
 - **Non-Participating Pharmacy:** Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM's directory of Participating Pharmacies.
 - **Non-Plan Provider:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires Prior Authorization from the Health Plan unless it is an Emergency or Urgent Care.
 - **Non-Preferred Drug:** Means a drug the PBM has determined offers less value and/or cost-effectiveness than Preferred Drugs. This would include Non-Preferred Generic Drugs, Non-Preferred Brand Name Drugs and Non-Preferred Specialty Medications included on the Formulary, which are covered by the benefits of this program with a higher Copayment.
 - **Medicare:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
 - **Medicare Prescription Drug Plan:** Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in Medicare Parts A and B, and eligible for Medicare Part D; and who are covered under a Medicare coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

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- **Nutritional Counseling:** This counseling consists of the following services:
 1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
 2. Re-assessment and intervention (individual and group)
 3. Diabetes outpatient self-management training services (individual and group sessions)
 4. Dietitian visit
- **Out-of-Area Service:** Means any services provided to Participants outside the Plan Service Area.
- **Out-of-Pocket Limit (OOPL):** The most You pay during a policy period (usually a calendar year) before Your Health Plan begins to pay 100% of the allowed amount. This limit never includes Your premium, balance-billed charges or charges for health care Your Health Plan does not cover.

Note: charges for Copayments such as emergency room and Level 3 prescription drugs, payments for out-of-network services or other expenses do not accumulate toward this limit.
- **Participant:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **Participating Pharmacy:** Means a pharmacy who has agreed in writing to provide the services to Participants that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
- **Plan Benefits:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
- **Plan Dependent:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
- **Plan Provider:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.
- **Plan Service Area:** Specific ZIP codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.
- **Postoperative Care:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **Preferred Drug:** Means a drug the PBM has determined offers more value and/or cost-effective treatment options compared to a Non-Preferred Drug. This would include Preferred Generic Drugs, Preferred Brand Name Drugs and Preferred Specialty Medications included on the Formulary, which are covered by the benefits of this program.
 - **Preferred Specialty Pharmacy:** Means a Participating Pharmacy which meets criteria established by the PBM to specifically administer Specialty Medication services, with which the PBM has executed a written contract to provide services to Participants, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one Participating Pharmacy as a Preferred Specialty Pharmacy.
 - **Preoperative Care:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital, or elsewhere, necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.
 - **Primary Care Provider:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.
- You should name Your Primary Care Provider or clinic on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.*
- **Prior Authorization:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in the Health Plan Descriptions section, of the *"It's Your Choice Decision Guide."* Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
 - **Provider:** Means (a) a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
 - **Referral:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in the Health Plan Descriptions section, of the *"It's Your Choice Decision Guide."* The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.

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- **Rehabilitation Services:** Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
- **Schedule of Benefit:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.
- **Self-Administered Injectable:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.
- **Shared Decision Making (SDM):** Means a program offered by a Health Plan or health care provider that Participants must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform Participants about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that Participants can decide the best possible course of treatment. The Health Plan or health care provider will provide the Participant with written Patient Decisions Aids (PDAs) as part of the SDM program.
- **Skilled Care:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, “Skilled Care” is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by “nonskilled” persons such as spouses, Domestic Partners, children or other family or relatives. Examples of care provided by “nonskilled” persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require “Skilled Care” and are considered Custodial.
- **Skilled Nursing Facility:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.
- **Specialty Medications:** Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all Participating Pharmacies; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.
- **State:** Means the State of Wisconsin as the policyholder.
- **Subscriber:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **Urgent Care:** Means care for an accident or illness which is needed sooner than a routine

doctor's visit. If the accident or Injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **Usual and Customary Charge:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals or Prior Authorizations to Non-Plan Providers are not subject to Usual and Customary Charges. Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary

Charges, however, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital/dental services.

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

III. Medical Benefits and Services

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

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

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

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

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

and services described below.

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

A. Medical/Surgical Services

1. Emergency Care

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

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reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

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

2. Urgent Care

- a. Medical care received in an Urgent Care situation as defined in section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the

Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan.

- c. Some examples of Urgent Care cases are:
 - o Most Broken Bones
 - o Minor Cuts
 - o Sprains
 - o Most Drug Reactions
 - o Non-Severe Bleeding
 - o Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for an Illness or Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants. This does not include oral surgery procedures, which are covered as described under 16. of this section.

Prior Authorization is required for Referrals to orthopedists and neurosurgeons associated directly or indirectly with the Health Plan for any Participant who has not completed an optimal regimen of conservative care for Low Back Pain (LBP). Prior Authorization is not required for a Participant who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty Referral.

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Participants seeking surgical treatment of LBP must participate in a credible Shared Decision Making (SDM) program provided by the Health Plan or its contracted providers consistent with the Prior Authorization requirement.

4. Reproductive Services and Contraceptives

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

- a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a Dependent daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn if the Dependent daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is Medically Necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.
- b. Elective sterilization.
- c. Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

- o Oral contraceptives, or cost effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
- o IUDs and diaphragms, as described under the Durable Medical Equipment provision.
- o Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

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

5. Medical Services

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

- a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.
- c. Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
- d. Colorectal cancer examinations and laboratory tests as required by Wis.

Stat. § 632.895 (16m).

- e. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)
- f. Injectable and infusible medications, except for Self-Administered Injectable medications.
- g. Nutritional Counseling provided by a participating registered dietician or Plan Provider.
- h. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.
- i. Preventive services as required by the federal Patient Protection and Affordable Care Act.

6. Anesthesia Services

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

7. Radiation Therapy and Chemotherapy

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

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider. Methadone Treatment shall be covered only when Medically Necessary and provided by an approved provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when Medically Necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route. This includes licensed professional air ambulance when another mode of ambulance service would endanger Your health. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained.

10. Diagnostic Services

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

Prior Authorization is required for Referrals to orthopedists and neurosurgeons associated directly or indirectly with the plan for Participants with a history of low back pain and who have not completed an optimal regimen of conservative care. Such Prior Authorizations are not required for Participants who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or

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other specialty Referral.

Prior Authorizations are required for high-tech radiology tests, including MRI, CT scan, PET scans and Nuclear Stress tests.

11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy

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

12. Home Care Benefits

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

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

- a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
- b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
- c. Physical, occupational and speech

therapy. (These apply to the therapy maximum.)

- d. Medical Supplies, drugs and medicines prescribed by a Health Plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Confined In A Hospital.
- e. Nutritional Counseling. A registered dietician must give or supervise these services.
- f. The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

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

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

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per calendar

year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating Your needs or developing a plan counts as one visit. Each period of four straight hours in a 24 hour period of home health aide services counts as one home care visit.

13. Hospice Care

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

Covers a one-time in-home palliative consult after the Participant receives a terminal diagnosis regardless of whether his or her life expectancy is six months or less.

Inpatient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility.

When benefits are payable under both this Hospice Care benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14. Phase II Cardiac Rehabilitation

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

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

Total extraction and/or total replacement (limited to, bridge, denture or implant) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the Health Plan before the service is performed. Coverage of one retainer or mouth guard shall be provided when Medically Necessary as part of prep work provided prior to accidental injury tooth repair. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision. Dental implants and associated supplies and services are limited to \$1,000 per tooth.

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16. Oral Surgery

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

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

and bone-graft replacement, when performed in place of a covered gingivectomy.

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

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

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

17. Treatment of Temporomandibular Disorders

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

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

This includes coverage of non-surgical

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

18. Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease.

a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

- o Aplastic anemia
- o Acute leukemia
- o Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
- o Wiskott-Aldrich syndrome
- o Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
- o Hodgkins and non-Hodgkins lymphoma

- o Combined immunodeficiency
- o Chronic myelogenous leukemia
- o Pediatric tumors based upon individual consideration
- o Neuroblastoma
- o Myelodysplastic syndrome
- o Homozygous Beta-Thalassemia
- o Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
- o Multiple Myeloma, Stage II or Stage III
- o Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b. Parathyroid transplantation.

c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.

d. Corneal transplantation (keratoplasty) limited to:

- o Corneal opacity
- o Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
- o Corneal ulcer
- o Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:

- o Congestive Cardiomyopathy

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- o End-Stage Ischemic Heart Disease
 - o Hypertrophic Cardiomyopathy
 - o Terminal Valvular Disease
 - o Congenital Heart Disease, based upon individual consideration
 - o Cardiac Tumors, based upon individual consideration
 - o Myocarditis
 - o Coronary Embolization
 - o Post-traumatic Aneurysm
- f. Liver transplants will be limited to the treatment of:
- o Extrahepatic Biliary Atresia
 - o Inborn Error of Metabolism
 - Alpha -1- Antitrypsin Deficiency
 - Wilson's Disease
 - Glycogen Storage Disease
 - Tyrosinemia
 - o Hemochromatosis
 - o Primary Biliary Cirrhosis
 - o Hepatic Vein Thrombosis
 - o Sclerosing Cholangitis
 - o Post-necrotic Cirrhosis, Hbe Ag Negative
 - o Chronic Active Hepatitis, Hbe Ag Negative
 - o Alcoholic Cirrhosis, abstinence for six or more months
 - o Epithelioid Hemangioepithelioma
 - o Poisoning
 - o Polycystic Disease
- g. Kidney with pancreas, heart with lung, and lung transplants as determined to be Medically Necessary by the Health Plan.
- h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize

a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.

- i. Kidney Transplants. See item 19 below.

19. Kidney Disease Treatment

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

20. Chiropractic Services

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

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies includes:

- o Reconstruction of the breast on which a mastectomy was performed;
- o Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- o Protheses (See DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- o Breast implants.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written

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prescription and are described under the Prescription Drug benefits in section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require Prior Authorization by the Health Plan.

B. Institutional Services

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

1. Inpatient Care

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

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

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

2. Outpatient Care

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

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

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

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

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

- a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as de-

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scribed in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37.

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

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided as required by an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be

subject to the prescription drug benefit as described in section D., 1.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered *subject to cost sharing as outlined in the Schedule of Benefits*. The Participant's Coinsurance will be applied to the annual Out-of-Pocket Limit. Durable diabetic equipment includes:

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

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

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

3. Medical Supplies And Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, Medical Supplies And Durable Medical Equipment will be covered *subject to cost sharing as outlined in the Schedule of Benefits*.

The following supplies and equipment will be covered only when Prior Authorized as determined by the Health Plan:

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- Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when Medically Necessary, and refitting of any existing prosthesis is not possible.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, as described in the Schedule of Benefits.
- One hearing aid, as described in the Schedule of Benefits. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
- Ostomy and catheter supplies.
- Oxygen and respiratory equipment for home use when authorized by the Health Plan.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of

covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to cost sharing as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual Out-of-Pocket Limit.

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

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

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

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the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

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

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

6. Coverage of Treatment for Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or

occupational therapist. Care up to \$50,000 per year for intensive-level and up to \$25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. The therapy limit does not apply to this benefit.

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

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

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

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

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

1. Prescription Drugs

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

An annual Out-of-Pocket Limit applies to Participants' Copayments for Level 1 and Level 2 Preferred prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual Out-of-Pocket Limit, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual Out-of-Pocket Limit as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual Out-of-Pocket Limit, all family members will have satisfied the annual Out-of-Pocket Limit for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual Out-of-Pocket Limit. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual Out-of-Pocket Limit for Level 1 and Level 2 Preferred prescription drugs.

The Health Plan, not the PBM, will be responsible for covering prescription

drugs administered during home care, office setting, Confinement, emergency room visit or Urgent Care setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, Confinement, emergency room visit or Urgent Care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, Self-Administered Injectable).

Medicare eligible Participants will be covered by a Medicare Part D prescription drug plan (PDP) provided by the PBM. Participants who choose to be enrolled in another Medicare Part D PDP other than this PDP will not have benefits duplicated.

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

In most instances, claims for Medicare Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for Participants with Medicare Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted provider administers the injection. If the HEALTH PLAN or a contracted provider is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claim to the PBM.

Prescription drugs will be dispensed as follows:

- a. In maximum quantities not to exceed

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- a 30 consecutive day supply per Copayment.
- b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).
- c. Single packaged items are limited to two items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d. Oral contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual Out-of-Pocket Limit. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year, unless the Participant obtains Prior Authorization for a limited extension.
- f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.
- h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- i. Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Preferred drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.
- j. Generic sampling is available to encourage the use of Level 1 Preferred medications, whereby the PBM may waive the Copayment of a Level 1 Preferred prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.
- k. The PBM reserves the right to designate certain over-the-counter drugs on the Formulary.
- l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the

Participant, must be obtained from a PBM Participating Pharmacy or Preferred Specialty Pharmacy. In some cases, the PBM may need to limit availability to specific pharmacies.

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

2. Insulin, Disposable Diabetic Supplies, Glucometers

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

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

3. Other Devices and Supplies

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

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

IV. Exclusions and Limitations

A. Exclusions

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

1. Surgical Services

- a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- b. Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
- c. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2. Medical Services

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services section.
- b. Expenses for medical reports, including preparation and presentation.
- c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by a Plan Provider to treat a metabolic or peripheral disease or a skin or tissue infection.
- d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits and Services section.
- e. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).
- f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be Services of a blood donor.
- g. Genetic testing and/or genetic counseling services, unless Medically

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Necessary to diagnose or treat an existing illness.

3. Ambulance Services

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

4. Therapies

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

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. §632.895 (12m) limit this exclusion.)

- c. Physical fitness or exercise programs.

- d. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

- e. Massage therapy.

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

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

6. Transplants

- a. Transplants and all related services, except those listed as covered procedures.
- b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.
- c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered

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- during the lifetime of the policy, except as required for treatment of kidney disease.
- d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
- e. All separately billed donor-related services, except for kidney transplants.
- f. Non-human organ transplants or artificial organs.

7. Reproductive Services

- a. Infertility services which are not for treatment of Illness or Injury (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.
- b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
- c. Services for storage or processing of semen (sperm); donor sperm.
- d. Harvesting of eggs and their cryopreservation.
- e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
- f. Surrogate mother services.
- g. Maternity services received out of the Plan Service Area one month prior to the estimated due date, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of

the Participant's control, for example, family emergency).

- h. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
- i. Services of home delivery for childbirth.
- j. Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8. Hospital Inpatient Services

- a. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.
- b. Hospital stays, which are extended for reasons other than medical necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.
- c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

9. Mental Health Services/Alcohol and Drug Abuse

- a. Hypnotherapy.
- b. Marriage counseling.
- c. Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37.
- d. Biofeedback.

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10. Durable Medical or Diabetic Equipment and Supplies

- a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.
- c. Medical Supplies And Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for 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.

11. Outpatient Prescription Drugs – Administered by the PBM

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

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- i. Charges for injectable medications, except for Self-Administered Injectable medications.
- j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.
- k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l. Infertility and fertility medications.
- m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.
- n. Charges for spilled, stolen or lost prescription drugs.

12. General

- a. Any additional exclusion as described in the Schedule of Benefits.
- b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if 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.
- 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

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- Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j. Maintenance Care.
 - k. Habilitation services and treatment, except as required by state law, including Wis. Stat. §§ 632.895 (5), (12m), and (16).
 - l. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).
 - m. 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.
 - n. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.
 - o. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
 - p. 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.
 - q. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery.
 - r. 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.
 - s. Charges for any missed appointment.
 - t. 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)

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- and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
- u. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
 - v. 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.
 - w. 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.
 - x. Coma stimulation programs.
 - y. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.
 - z. Any diet control program, treatment, or supply for weight reduction.
 - aa. 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).

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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 and sexual transformation.
- 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.

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.

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,
- 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.

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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 arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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4. "Primary Plan"/"Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

5. "This Plan" means the part of Your group contract that provides benefits for health care and pharmaceutical expenses.

The benefits of the Plan which covers the person as an employee or Participant are determined before those of the Plan which covers the person as a Dependent of an employee or Participant.

- b. Dependent Child/Parents Not Separated or Divorced

Except as stated in subparagraph 2., c. below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 1. above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

- c. Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) first, the Plan of the parent with custody of the child;

2) then, the Plan of the spouse of

C. Order Of Benefit Determination Rules

1. General

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

- the other Plan has rules coordinating its benefits with those of This Plan; and
- both those rules and This Plan's rules described in subparagraph 2 require that This Plan's benefits be determined before those of the other Plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- Non-Dependent/Dependent

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the parent with the custody of the child; and

- 3) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C., 2., b.

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

d. Active/Inactive Employee

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

e. Continuation Coverage

- 1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall Determine the order of benefits:

- i. First, the benefits of a plan covering the person as an employee, member, or subscriber or as a dependent of an employee, member, or subscriber.
- ii. Second, the benefits under the continuation coverage.

- 2) If the other plan does not have the rule described in subparagraph 1), and if, as a result, the plans do not agree on the order of benefits, this Paragraph e. is ignored.

f. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

3. Coordination of Dental Benefits

The dental benefits under Uniform Benefits provided by a Health Plan are considered to be primary with regards to stand-alone or wrap-around dental plans that are approved by the Group Insurance Board and held by employees, annuitants, and continuants pursuant to Wis. Adm. Code Ins. 3.40 (9) (d).

D. Effect on the Benefits of the Plan

1. When This Section Applies

This section D. applies when, in accordance with section C., Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other Plans” in subparagraph 2. below.

2. Reduction in This Plan’s Benefits

The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

- a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
- b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right to Receive and Release Needed Information

The Health Plan has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under This Plan must give the Health Plan any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. The Health Plan will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

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

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

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the Health Plan, provide any relevant and reasonably available information which the Health Plan believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

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

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

B. Physical Examination

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

C. Case Management/Alternate Treatment

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

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

If the Health Plan agrees to the attending physician's recommendation or if the Participant or his/her authorized representative and the attending physician agree to the Health Plan's recommendation, the recommended treatment will be provided as soon as it is

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available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

D. Disenrollment

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

Change to an alternate Health Plan via It's Your Choice enrollment is available during a regular It's Your Choice open enrollment period, which begins a minimum of 12 months after the disenrollment date.

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

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be

transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent It's Your Choice open enrollment periods. Reenrollment in the Health Plan is available during a regular It's Your Choice open enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery of Excess Payments

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

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

F. Limit on Assignability of Benefits

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

G. Severability

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

H. Subrogation

Each Participant agrees that the insurer under these Uniform Benefits, whether

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

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

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

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

over the question of whether or not the Participant has been "made whole", the insurer reserves the right to a judicial determination whether the insured has been "made whole."

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

Miscellaneous Provisions: Local Participants 2015

I. Proof of Claim

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

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

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

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

J. Grievance Process

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

If You exhaust the Health Plan's and/or PBM's

Grievance process and remain dissatisfied with the outcome, You may appeal to the Department by completing a Department complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department within 60 days of the date of the final grievance decision letter from the Health Plan and/or PBM.

However, You may not appeal to the Department 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. You may request an independent review pursuant to Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, You have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals to The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent

Review Organization decision that is final and binding 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.

Uniform Medical Benefits Quick Reference: Local Participants 2015

Note: The Quick Reference Guide is intended only to help locate the most commonly used benefits and services listed in the Uniform Benefits section of the 2015 *It's Your Choice Reference Guide*. It is not part of Your insurance contract or a comprehensive listing of benefits, services, exclusions or limitations in Your health plan. As such, it should not be relied on as a comprehensive listing of items contained within Your insurance contract or the 2015 *It's Your Choice Reference Guide*.

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Uniform Dental Benefits (Certificate of Coverage)

Please read the following information carefully for Your procedure frequencies and provisions.

All dental benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. The Uniform Dental Benefits are wholly incorporated in the Master Contract.

This is a list of Uniform Dental Benefits and is based upon the Current Dental Terminology © American Dental Association. Codes are provided as a reference and may be subject to change; plans may substitute alternative codes to provide essentially equivalent coverage.

Definitions

Dental Plan Administrator: The Health Plan or third party administrator responsible for providing dental insurance benefits under the Group Insurance Board's program, and which is chosen by the enrolled subscriber's Health Plan to provide the Uniform Dental Benefits during the calendar year.

Dental Plan: Means all benefits, limitations, and exclusions included in the Uniform Dental Benefit Certificate.

Dental Provider: Means a dentist or any other person or entity licensed by the state of Wisconsin, or other applicable jurisdiction, to provide one or more Dental Plan benefits.

Designated In-Network Dental Provider: Means a Dental Provider who has been approved for in-network level payment by the Health Plan for providing dental services, but does not have a written agreement to provide direct dental care services, supplies, or other items covered under the policy to participants. These providers are determined by the Health Plan, specifically for areas in which there is insufficient access to in-network providers. The Health Plan is not required to have Designated In-Network Dental Providers.

In-Network Dental Provider: A Dental Provider who has agreed in writing by executing a participation agreement to provide or direct dental care services, supplies, or other items covered under the policy to participants. The Dental Provider's written participation agreement must be in force at the time of such services, supplies or other items covered under the policy are provided to the participant.

Out-of-Network Dental Provider: Means a Dental Provider who does not have a signed participating Dental Provider agreement and is not listed on the most current edition of the Dental Plan's professional directory of In-Network and Designated In-Network Dental Providers. Health Plans that wish to offer out-of-network coverage will use the reimbursement rates as listed in the Key Contract Provisions chart on Page 79.

Note: Check with your Dental Plan Administrators to see if you have out-of-network coverage.

No payment will be made for a benefit that is not listed.

- Your benefits are based on a calendar year. A calendar year runs from January 1 through December 31.
- During the first year a person is insured, benefits begin on the Effective Date and continue through December 31 of that year.
- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for Health Plan review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.
- Note that Uniform Benefits may provide coverage for oral surgery.

Limitations

The following services **are limited** under this Dental Plan:

- Oral Exams limited to two per year.
- Full Mouth or Panoramic x-rays limited to once every 60 months.
- Bite wing x-rays limited to two sets per year.
- Cleaning of teeth limited to two times per year.
- Fluoride treatment allowed only for a child under age 19, limited to two times per year.
- Sealants allowed only for a child under age 16, and must be applied to non-restored, non-decayed first and second permanent molars, limited to once per tooth per lifetime.
- Routine pediatric dental services as required under federal law.

****Special note on fillings:** On anterior (front) teeth You will have 100% coverage subject to Your benefit maximum for both amalgam (silver) and composite/resin (tooth colored) fillings. On posterior (back) teeth, You have 100% coverage subject to Your benefit maximum for amalgam (silver) fillings only. If You have a composite/resin (tooth colored) filling on a posterior tooth, You will be responsible for the difference between the amount Your provider charges for an amalgam and a composite/resin filling.

Uniform Dental Benefits: Local Participants 2015

Exclusions

The following are **not covered services** under this Dental Plan:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer Liability laws.
2. Services or appliances started prior to the date the patient became eligible for coverage under the State of Wisconsin's Group Health Insurance Program's Uniform Dental Benefit.
3. Prescription drugs, pre-medications or relative analgesia charges for anesthesia in connection with covered oral surgery procedures.
4. Preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. Appliances, restorations or procedures for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques or for splints, unless necessary as a result of accidental injury.
9. Replacement of lost or broken retainer.
10. Treatment by other than a Dental Provider, his or her employees, or his or her agents. A Dental Plan Administrator may designate and authorize out-of-network providers in the absence of an existing in-network provider or provider network.
11. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
12. Claims not submitted to the Dental Plan Administrator within 12 months, or if later, as soon as reasonably possible, from the date the procedure was provided.
13. Dental procedures in cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Procedures and services not specifically provided under this Certificate of Coverage and procedures and services excluded by Dental Plan.
15. Any oral surgical procedures not specifically listed as a covered benefit or for which coverage exists under Uniform Benefits.

Uniform Dental Benefits: Local Participants 2015

Key Contract Provisions¹ Only certain Dental Plan Administrators offer out-of-network coverage. Contact Your Dental Plan Administrator for details on Your network coverage.			Covered Services (Examples)
	In-Network and Designated In-Network Provider	Out-of-Network Provider²	
Deductible:	\$0	\$0	
Annual Benefit Max:	\$1,000 per participant	\$1,000 per participant	
Diagnostic / Preventive:	100%	75%	<ul style="list-style-type: none"> • Routine Evaluations • X-rays • Fluoride
Restorative:	100%	50%	<ul style="list-style-type: none"> • Fillings
Periodontic:	80%	50%	<ul style="list-style-type: none"> • Limited to Periodontal Maintenance
Adjunctive Services:	80%	50%	<ul style="list-style-type: none"> • Local Anesthesia
Ortho:	50% (children only)	50% (children only)	
Ortho Lifetime Max:	\$1,500 per participant	\$1,500 per participant	

¹ Note: Dental benefits under the High Deductible Health Plan (HDHP) will be subject to the HDHP deductible and the coinsurance as listed above.

² Check with Your Dental Plan Administrator to find out if You have out-of-network dental benefits.

Diagnostic/Preventative:

Routine Oral Evaluation - exams are limited to two per year.

Note that comprehensive exams are not done multiple times in a year.

- D0120 Periodic oral evaluation.
- D0145 Oral evaluation for patient under three years of age.
- D0150 Comprehensive oral evaluation – new/established patient or a patient who has been absent from dental care for more than three years; included as one of the two exams per year.
- D0160 Detailed & extensive oral evaluation.
- D0180 Comprehensive perio evaluation – new/established patient; included as one of the two exams per year.

Limited Oral Evaluation

- D0140 Limited oral evaluation - problem focused.

Complete Series or Panoramic Film: limited to one (either D0210 or D0330) once every 60 months.

- D0210 Intraoral - Complete including bitewings.
- D0330 Panoramic radiographic image.

Uniform Dental Benefits: Local Participants 2015

Other X-rays

- D0220 Intraoral periapical first radiographic image.
- D0230 Intraoral periapical additional radiographic image.
- D0240 Intraoral occlusal radiographic image.
- D0250 Extraoral first radiographic image.
- D0260 Extraoral each additional radiographic image.

Bitewing Films - limited to two sets per year.

- D0270 Bitewing single radiographic image.
- D0272 Bitewings two radiographic images.
- D0273 Bitewings three radiographic images.
- D0274 Bitewings four radiographic images.
- D0277 Vertical bitewings 7 to 8 radiographic images.

Prophylaxis (Cleaning) and Fluoride:

Prophylaxis: D1110, D1120

- D1110 Prophylaxis (cleaning) – Adult; limited to twice per year.
- D1120 Prophylaxis (cleaning) – Child; limited to twice per year.

Fluoride - limited to twice per year up to age 19.

- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride.

Sealant

- D1351 Sealant - per tooth; limited to once per lifetime up to age 16, first and second molars only.

Space Maintainers - limited to primary teeth lost prematurely

- D1510 Space maintainer fixed unilateral.
- D1515 Space maintainer fixed bilateral.
- D1520 Space maintainer removable unilateral.
- D1525 Space maintainer removable bilateral.
- D1550 Recementation space maintainer.
- D1555 Removal of fixed space maintainer.

Restorative:

Amalgam Restoration

***see note on fillings on page 77 of this certificate*

- D2140 Amalgam filling - one surface.
- D2150 Amalgam filling - two surfaces.
- D2160 Amalgam filling - three surfaces.
- D2161 Amalgam filling – four/more surfaces.

Resin Restorations

***see note on fillings on page 77 of this certificate*

- D2330 Resin filling - one surface anterior.
- D2331 Resin filling - two surfaces anterior.
- D2332 Resin filling - three surfaces anterior.
- D2335 Resin filling – four/more surfaces anterior.
- D2390 Resin Crown anterior.
- D2391 Resin filling - one surface posterior; benefits limited.
- D2392 Resin filling - two surfaces posterior; benefits limited.
- D2393 Resin filling - three surfaces posterior; benefits limited.
- D2394 Resin filling – four/more surfaces posterior; benefits limited.

Miscellaneous Restorative

- D2940 Sedative filling; limited to once per lifetime per tooth.
- D2951 Pin retention per tooth; limited to once per tooth.
- D2999 Unspecified restorative procedure by report.

Periodontic:

- D4910 Periodontal maintenance. Coverage is limited to two procedures per one benefit period calendar year in addition to routine cleanings.

Oral Surgery:

Please note that eligible oral surgical procedures are covered under Uniform Benefits when furnished by a covered Dental Provider.

Adjunctive Services:

- D9110 Emergency treatment/palliative.
- D9210 Local anesthesia not in conjunction with operative or surgical procedures.
- D9215 Local anesthesia used in conjunction with operative or surgical procedures.
- D9220 General anesthesia – 30 minutes.
- D9221 General anesthesia – 15 minutes.
- D9230 Nitrous oxide sedation.
- D9241 Intravenous sedation analgesia – 30 minutes.
- D9242 Intravenous sedation analgesia – 15 minutes.
- D9610 Therapeutic parenteral drug, single administration.
- D9612 Therapeutic parenteral drugs.
- D9910 Application of Desensitizing.
- D9911 Apply desensitizing resin.
- D9930 Treatment of complications.
- D9999 Unspecified adjunctive procedure.

Uniform Dental Benefits: Local Participants 2015

Orthodontic Services - limited to age 19, 50% coverage.

- D8010 Limited orthodontic treatment of primary dentition.
- D8020 Limited orthodontic treatment of transitional dentition.
- D8030 Limited orthodontic treatment of adolescent dentition.
- D8040 Limited orthodontic treatment of adult dentition.
- D8050 Interceptive orthodontic treatment of primary dentition.
- D8060 Interceptive orthodontic treatment of transitional dentition.
- D8070 Comprehensive orthodontic treatment of transitional dentition.
- D8080 Comprehensive orthodontic treatment of adolescent dentition.
- D8090 Comprehensive orthodontic treatment of adult dentition.
- D8660 Pre-orthodontic treatment visit; may also be billed out as any combination of D0330, D0340, D0350, and D0470.
- D8680 Orthodontic retention (removal of appliances, construction/placement).
- D8690 Orthodontic treatment (alternative billing to a contract fee).
- D8999 Unspecified orthodontic procedure, by report.
- D9310 Consultation – diagnostic services other than requesting provider.

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Where to Get More Information

If you need additional information regarding:

- Benefits
- Exclusions
- Participating Providers
- Limitations

Contact the Health Plan or Pharmacy Benefit Manager (PBM) directly. Addresses, Websites* and telephone numbers are listed on the Inside Back Cover of the *It's Your Choice Decision Guide*.

* When using Health Plan websites for benefit and provider data, ensure that you are accessing Wisconsin Public Employer program specific information. If you are not sure, call the Health Plan.

If you need additional information regarding:

- Applications
- Eligibility
- Enrollment
- General Information

Contact your benefits/payroll/personnel office. If you are an annuitant or are on continuation coverage, contact:

Employee Trust Funds
PO Box 7931
Madison, WI 53707-7931
1-877-533-5020 (toll free)
608-266-3285 (local Madison)
Fax: 608-267-4549

All changes in your subscriber information, family status or providers must be made through your benefits/payroll/personnel office, and may be submitted electronically or via paper on approved forms. Annuitants and continuants should submit to ETF.

Additional information is available at etf.wi.gov.

Comments and suggestions regarding the It's Your Choice guides should be directed to the Program Manager—Health Plans, Division of Insurance Services.

Stay Informed

Get free ETF E-mail Updates



Look for the red envelope at etf.wi.gov

Wisconsin Department of Employee Trust Funds

801 W. Badger Road
(visitor address)

PO Box 7931
Madison, WI 53707-7931
(mailing address)

1-877-533-5020 (toll free)
608-266-3285 (local to Madison)
Fax 608-267-4549

